Arizona Department of Corrections

Appendix G of the Health Services Technical Manual

Revised August 15th, 2011

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Arizona Department of Corrections	Administration of Mental Health Services	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 1.0	Supersedes: MHTM 1.0 Effective Date: 8/15/11

Purpose: Arizona Department of Corrections, Mental Health Services shall be administrated through the Division of Health Services under the general direction of the Division Director of Health Services with the assistance of the Mental Health Program Manager, or designee. The day-to-day operation of Mental Health Services is assigned to the local Facility Health Administrator, who operates within ADC Department Orders and under the provisions of the Mental Health Technical Manual.

Responsibility: The responsibility for the management of mental health service provision within the Department is jointly shared by the relevant mental health personnel identified in this policy.

1.0 Definitions

1.1 Division Director of Health Services - That person designated by the Director to direct the provision of all Health Services to inmates of the Arizona Department of Corrections.

1.2 Mental Health Program Manager – The Staff member assigned by the Division Director of Health Services to plan and direct Mental Health Services provided to inmates of the Arizona Department of Corrections.

1.3 Director of Psychiatry - That person designated by the Division Director Health Services to provide clinical supervision to staff psychiatrists and psychiatric nurse practioners. This individual develops policy related to the delivery of psychiatric services and psychotropic medication use.

1.4 Nursing Program Manager - That person designated by the Division Director of Health Services to plan and direct Nursing Services provided to inmates of the Arizona Department of Corrections.

1.5 Facility Health Administrator - That person designated by the Division Director of Health Services to provide day-to-day direction to all health services at an ADC complex/facility.

1.6 Clinical Director – Staff member who coordinates the day-to-day operation of the licensed mental health facility and reports to the Mental Health Program Manager.

1.7 Chief Psychologist [Psychologist III] coordinates the day-to-day operation of all Mental Health Services and provides clinical services on the ADC complex(es) under his/her responsibility and reports to the Facility Health Administrator and Mental Health Program Manager.

1.8 Psychiatric Nurse Coordinator– Staff member designated to the supervision and administration of Psychiatric Nursing services at ASPC-Phoenix.

1.9 Correctional Nursing Supervisor II - Person designated to the supervision of nursing services, including Psychiatric Nursing services, at all other complexes and facilities.

1.10 Mental Health staff - Psychologists, Psychiatric Nurse Practitioners, Psychology Associates, Mental Health Therapists, Psychiatric RNs, Psychiatrists, Recreational Therapists, Occupational Therapists, Mental Health CO IIIs, Mental Health COIVs, Psychotherapy Program Representatives, Psychology Assistant.

2.0 Local Administration of Mental Health Services

2.1 There shall be, at each ADC complex/facility, a Mental Health Team that shall assume full responsibility for the implementation of Mental Health programming and services to address the mental health needs of inmates. The purpose of this team shall be to provide overall direction of Mental Health Services at that complex/facility. Members of that team may include:

2.1.1 The Chief Psychologist or designee.

2.1.2 The Chief Psychiatrist, or designee

2.1.3 The Psychiatric Nurse Coordinator (ASPC-Phoenix).

2.1.4 Other staff members may be asked to serve on the Mental Health Management Team as determined by the Chief Psychologist.

2.2 The responsibilities of the Mental Health Team will include at a minimum:

2.2.1 Establishing and monitoring compliance with facility Mental Health procedures that assure a cohesive team approach to the provision of Mental Health Services on every yard.

2.2.2 Ensure that there exists a procedure for a monthly (minimum) meeting of all Mental Health staff assigned to provide services on each yard.

2.2.3 Ensure that Mental Health services and status decisions such as SMI status, Mental Health scores, and treatment planning are done in accordance with current policy.

2.2.4 Development of programs and services and establishment of facility protocols for the delivery of required services to address the identified needs in keeping with Department and divisional direction.

2.2.5 Review of situations involving the delivery of Mental Health Services to specific inmates that have not been satisfactorily resolved at a lower level and/or require a higher level of care than is locally available.

2.2.6 Providing administrative direction to Mental Health Services and assuring compliance with completion of job responsibilities for all staff members.

2.2.7 Responding to recommendations, directives, and requests from the Division of Health Services, Central Office, other Divisions of the Department of Corrections, and The Board of Executive Clemency, etc., as they relate to Mental Health Services and issues.

2.2.8 Assuring compliance with Division of Health Services data collection and assessment policies and generation of the monthly Mental Health Services Report

2.3 To accomplish the foregoing, the Mental Health Team shall operate under the following guidelines:

2.3.1 The Team shall meet, at a minimum, once a month or more often as determined by the Chief Psychologist.

2.3.2 Minutes will be kept and be available for review.

2.4 Roles of Mental Health Treatment Team Members:

2.4.1 Chief Psychiatrist (or designee)

2.4.1.1 Serves as an expert resource to all health staff regarding psychiatric issues.

2.4.1.2 Participates in the clinical Mental Health Treatment Team meetings on the yard to which he/she is assigned and assures attendance of other Psychiatrists/Psychiatric Nurse Practitioners within the complex/facility at the Mental Health Treatment Team meetings held on the yards to which they are assigned.

2.4.1.3 Other duties and responsibilities as assigned by the team, the Facility Health Administrator, ADC orders, Division of Health Services procedures, and/or the Division Director of Health Services.

2.4.2 Chief Psychologist

2.4.2.1 Serves as an expert resource to all Health staff regarding Psychological issues.

2.4.2.2 Coordination of the day-to-day complex/facility Mental Health Services, to include, but not be limited to:

2.4.2.2.1 Assuring compliance with directives, goals, and procedures as established by the team or the FHA, ADC orders and Division of Health Services procedures, and directives from the Division Director of Health Services.

2.4.2.2.2 Scheduling of mental Health Staff to assure compliance with program requirements and appropriate mental health coverage.

2.4.3 Psychiatric Nurse Coordinator (ABHTF)

2.4.3.1 Member of the Mental Health Treatment Team at Alhambra Behavioral Health Treatment Facility.

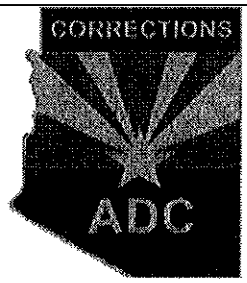
2.4.3.2 Serves as an expert resource to all health staff regarding Psychiatric Nursing issues.

2.4.3.3 Assures that Psychiatric Nursing personnel are responsive to the directives and requests of Psychiatrists and Psychiatric Nurse Practitioners. This should include, but not be limited to:

2.4.3.3.1 Scheduling and maintenance of Psychiatrist's and Psychiatric Nurse Practitioner's line.

2.4.3.3.2 Acknowledging medication, laboratory, and other Psychiatrist and Psychiatric Nurse Practitioner orders and following through as appropriate.

2.4.3.3.3 Provides direct clinical services.

 Arizona Department of Corrections	Monthly Reporting of Mental Health Statistics	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 2.0	Supersedes: Procedural Instruction AD0005 Effective Date: 8/15/11

Purpose: To describe how Mental Health statistics will be collected and reported on a monthly basis.

Responsibility: The Chief Psychologist [or designated staff at non-corridor complexes] at each ADC complex is responsible for completing, compiling, and forwarding the monthly Mental Health statistics to the individual(s) identified in this policy.

1.0 At the end of each month, every Mental Health staff member will compile the following information and submit this information to the Chief Psychologist:
- 1.1 Number of inmates participating in group at the end of the month
- 1.2 Number of inmates who have completed group during the month
- 1.3 Total number of inmate contacts for the month (i.e. those inmates for whom an entry was made in the progress notes of the MH section of the medical file, HNR responses, Inmate Letter responses, 14-day evaluations).
  - 1.3.1 Sections 1.1 through 1.3 of this policy apply to psychology and psychiatric staff, Mental Health Corrections officers, and Mental Health Re-entry Planners.
- 1.4 Number of HNRs received/responded to.

2.0 At the end of the month, each Mental Health staff member assigned to work in a specialized Mental Health program will compile the following information and submit this information to the Chief Psychologist:
- 2.1 Number of inmates participating in the program at the end of the month
- 2.2 Number of inmates who have completed the program during the month
- 2.3 Total number of inmate contacts for the month

3.0 At the end of the month, the Mental Health Release Planner will report the following information and submit the information to the Chief Psychologist:
- 3.1 Number of Community MH referrals
- 3.2 Number of completed AHCCCS applications
- 3.3 Total number of inmate contacts for the month

4.0 The Chief Psychologist will submit the Mental Health Monthly Reporting to the designated Central Office Mental Health staff member

5.0 The Chief Psychologist shall retain copies of all staff members' Monthly Reporting forms.

6.0 One Monthly Reporting form shall be prepared for each separate rural, non-corridor complex and submitted by a designated Mental Health staff member on complex to the designated Central Office Mental Health staff member.

Arizona Department of Corrections	Psychiatric and Mental Health Peer Review	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 3.0	Supersedes: Procedural Instruction AD0002, MHTM 23.0, MHTM 24.0, Effective Date: 8/15/11

Purpose: To provide a standardized peer review procedure for the assurance of the quality of care and content of records for each mental health staff person to include psychiatrists and psychiatric mid-level providers.

Responsibility: It is the responsibility of each supervisor within Mental Health to ensure that each subordinate supervisee provides the highest quality mental health service, and that the documentation of such services is correctly recorded in accordance with ADC policy.

1.0 Psychology Peer Reviews

1.1 Each supervisor shall, on an annual basis, conduct a thorough review of the mental health section of five (5) inmate medical charts for each mental health staff member they supervise and complete the Peer Review Checklist.

1.2 The Mental Health section will be reviewed completely, to include the:

1.2.1 Quality of service delivery
1.2.2 Thoroughness of assessment
1.2.3 Follow-up
1.2.4 Referrals made for mental health services/programs [when needed]
1.2.5 Treatment planning
1.2.6 Adherence to documentation timeframes
1.2.7 Quality of documentation (legibility, format, inclusiveness, appropriateness of notes, etc.) shall be noted and discussed with supervisee.

1.3 Additionally the file as a whole shall be reviewed for elements such as SMI tag (brown tag), completeness of problem list, MH score, SMI checklist, informed consents, etc.

1.4 The supervisor will provide each staff member a copy of the Peer Review Checklist for each review completed.

1.5 The staff member will have 30 calendar days to correct any deficiencies and return the form.

1.6 When corrections are completed, the form is to be signed and returned to the supervisor.

1.7 Peer reviews will be completed to coincide with PACE reviews.

2.0 Psychiatry Peer Reviews

2.1 Each psychiatric supervisor shall, on an annual basis, shall conduct a thorough review of (5) five inmate medical charts for each psychiatric staff member they supervise and complete the Peer Review Checklist.

2.2 The Mental Health section will be reviewed completely, to include the:

2.2.1 Medical and Mental Health SOAP notes

2.2.2 Medication sheets/orders

2.2.3 Lab work/reports

2.2.4 X-rays,

2.2.5 Consults and the need therefore

2.2.6 HNR's for the (6) six month period prior to the review

2.3 The review should focus on the preceding (90) ninety to (180) one-hundred and eighty days if possible.

2.4 The records being reviewed will include at least (3) three chosen at random, from the provider's appointment list, and may include up to (2) two chosen at the Chief Psychiatrist's discretion.

2.5 The records of the Chief Psychiatrist shall be reviewed according to the following:

2.5.1 The Medical Record supervisor will randomly select (2) two charts for psychiatric review and forwarded to the Director of Psychiatry, or designee, for review. The material to be reviewed will include:

2.5.1.1 All SOAP notes

2.5.1.2 Mental Health records

2.5.1.3 Lab work

2.5.1.4 X-ray

2.5.1.5 Consultations

2.5.1.6 Health Needs Requests for the (6) six month period prior to the review

2.6 For each medical record reviewed, information gathered shall be recorded on the appropriate Psychiatric Peer Review Form.

2.6.1 A separate form shall be utilized for each medical record reviewed.

2.6.2 Reviewing psychiatrists are to retain all copies of reviews.

2.7 A formal peer review or case review may be requested relative to inmate health care by the Facility Health Administrator, Mental Health Program Manager, or designee, or the Division Director of Health Services.

2.8 In those complexes which do not have a Chief Psychiatrist, Peer Reviews will be completed by the Director of Psychiatry.

Arizona Department of Corrections	Medical Records Review for Inmate Arriving on Unit	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 4.0	Supersedes: Procedural Instruction, TR0003 Effective Date: 8/15/11

Purpose: This procedure is intended to ensure that each inmate's medical record shall be reviewed by mental health staff upon arrival at a new complex or unit. This information will be used to alert mental health staff about significant issues for each new inmate on-unit.

Responsibility: Assigned mental health/medical personnel completing the medical chart reviews are responsible for making referrals for further health services when indicated.

1.0 Procedure
- 1.1 The review of medical files shall:
  - 1.1.1 Be completed by assigned medical/mental health staff on unit
  - 1.1.2 Be documented on a SOAP note in the inmate's medical chart by the reviewing staff
  - 1.1.3 Include any additional documentation regarding referrals to specialized health care services relating to mental health programming
  - 1.1.4 Occur daily at each complex.
- 1.2 The file review shall consist of the following:
  - 1.2.1 Problem List
    - 1.2.1.1 Current Mental Health score and need level
    - 1.2.1.2 SMI status
    - 1.2.1.3 Suicide history (if any)
    - 1.2.1.4 Add this information if not on Problem List
  - 1.2.2 Mental Health Assessment
  - 1.2.3 Mental Health section
- 1.3 The information resulting from the file review will be made available to the mental health staff on the inmate's receiving unit within one working day.
- 1.4 Whenever an inmate is identified as at significant risk the receiving unit will be contacted immediately so that an assessment of the inmate in question can occur that same day (when possible).

Arizona Department of Corrections	Weekly Mental Health Teleconference	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 5.0	Supersedes: MHTM 25.0 Effective Date: 8/15/11

Purpose: To provide for on-going, effective, and timely communication between mental health staff at the Alhambra Behavioral Health Treatment Facility [ABHTF] and all other complexes/facilities regarding inmates who may potentially require intensive mental health treatment at the ABHTF.

Responsibility: The Clinical Director, or designee, is responsible for moderating the content and direction of the weekly Mental Health teleconference.

1.0 It is the policy of the Arizona Department of Corrections that, on Tuesday of every week, at 1330 hours (subject to change), a teleconference will be held with the ABHTF mental health staff and other complex/facility mental health staff as outlined below. The purpose of the teleconference is to discuss:
- 1.1 The mental health treatment needs of inmates being referred to or from ABHTF.
- 1.2 In a consultative manner, the provision of mental health care services and/or mental health care programming options with regards to difficult cases.

2.0 The Clinical Director of ABHTF, or designee, will conduct and chair the weekly telephone conference.
- 2.1 To participate in the teleconference, mental health staff will dial a phone number designated by the State operator for the teleconference.
  - 2.1.1 If an alternate number is needed, the Clinical Director of ABHTF, or designee, will provide this number to the appropriate Mental Health personnel no later than (24) twenty-four hours prior to the teleconference.
- 2.2 The Chief Psychologists [PSY III] at ASPC-Perryville, ASPC-Phoenix, ASPC-Tucson, ASPC-Eyman, ASPC- Lewis, and ASPC-Florence will assure and arrange for participation by at least one licensed clinical psychologist from their facility.
- 2.3 Other personnel (including the FHA) are encouraged to participate.
- 2.4 The Chief Psychologists for other complexes/facilities will assure and arrange for participation by their mental health staff as determined by their need to seek consultation regarding an inmate's mental health service needs.
- 2.5 The format for the teleconference provides an opportunity for ABHTF mental health staff to consult with staff from other complexes/facilities on issues

including referrals/releases, consultations, and inquires on the provision of inmate mental health care.

2.6 When admission to ABHTF is being considered, or when a review of an inmate treatment is indicated, the Teleconference Presentation form will be completed by staff in advance of the meeting and forwarded to the Clinical Director who will add the referral to the meeting's agenda.

2.7 The Clinical Director of ABHTF will designate an individual to keep a record of topics discussed during the teleconference.

2.7.1 Other complex/facility mental health staff will receive this record through their Chief Psychologist.

2.8 In the event that a teleconference has to be cancelled or re-scheduled, the Clinical Director of ABHTF will so notify participants by way of their Chief Psychologist.

Arizona Department of Corrections	Mental Health Urgent Responder Protocols	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 6.0	Supersedes: Procedural Instruction AD0007 Effective Date: 8/15/11

Purpose: To provide guidance and procedure regarding the operation of after hours, nights, and holiday Mental Health Urgent Response.

Responsibility: All Mental Health and Psychiatric Urgent Responders are responsible for the Mental Health Urgent response duties outlined in the below policy.

1.0 Scheduling
- 1.1 Each eligible Mental Health staff member will receive training from their supervisor in ADC Urgent Response procedures.
- 1.2 Upon completion of the orientation to the Urgent Response procedures each trained staff person will be scheduled on the Urgent Response on a regular basis.
- 1.3 Assigned duty for the primary Urgent Responder runs from 1700 each Tuesday until 1659 the following Tuesday. If an Urgent Responder is unable to complete their assigned week they are required to:
  - 1.3.1 Contact other Urgent Response providers to arrange coverage for their absence (swapping of assigned shifts requires the prior approval of the Mental Health Program Manager).
  - 1.3.2 Contact the Mental Health Program Manager, or designee, in emergency/short notice situations where arranging alternate coverage is unrealistic.

2.0 Mental Health Urgent Response Procedure
- 2.1 When an Urgent Responder receives a page or telephone call from any complex, the Urgent Responder shall initiate contact within (10) ten minutes. The call shall be placed by an on-duty nurse who is familiar with the current inmate crisis. In the even that a nurse is unavailable to make the call, security staff place the inmate on a temporary constant watch until a nurse can be located.
- 2.2 The Urgent Responder shall obtain all available relevant information regarding the corresponding situation, to include the inmates:
  - 2.2.1 Housing placement (Complex and unit)
  - 2.2.2 Verbalizations and/or behaviors
  - 2.2.3 Physical condition
  - 2.2.4 Severity of self injurious behavior (if present)
  - 2.2.5 Severity of aggressive/assaultive behavior (if present)

2.3 If a placement on a watch is indicated, the on-duty nurse must complete the Mental Health Disposition (Form 1103-44) with the instructions provided by the Urgent Responder.

2.4 The Urgent Responder shall request the on-duty nurse to read back the orders to ensure that the Urgent Responder's required actions were clearly understood.

2.5 The Urgent Responder shall contact the Psychiatric Urgent Responder when psychotropic medication intervention is required (with the exception of the Alhambra Behavioral Health Treatment Facility).

2.6 On-duty nursing staff shall document the crisis, the reason for the watch, and the name of the Urgent Responder that was contacted along with their recommendations.

Arizona Department of Corrections	Supervision of Unlicensed Mental Health Staff	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 1 Section 7.0	Supersedes: Procedural Instruction AD0009 Effective Date: 8/15/11

Purpose: To provide direction and procedure regarding mental health program staff not licensed to practice independently. Outlined in this policy are elements pertaining to the clinical supervision of such individuals by licensed mental health staff to ensure minimum mental health care requirements are met. This policy provides direction regarding the clinical supervision of unlicensed mental health staff providing mental health services to the Arizona Department of Corrections offender population.

Responsibility: It is the responsibility of the Chief Psychologist to ensure that all Psychologist ~~Hs~~ who supervise unlicensed mental health staff personnel complete and abide by the clinical supervision requirements outlined in the below policy.

1.0 Definitions

1.1 Psychologist means an individual independently licensed within the state of Arizona who can use the title Psychologist as defined in A.R.S. 32-3601 and A.A.C. Title 4, Chapter 26. A Psychologist may hold the job title of Psychologist II, Psychologist III, ADC Clinical Director, or ADC Mental Health (MH) Program Manager.

1.2 Psychology Associate or Psychology Assistant means an individual who has obtained a doctoral or master's degree in a mental health field, is employed within the ADC job classification of Psychology Associate II or Psychology Assistant, and provides mental health services to offenders confined to ADC.

1.3 Unlicensed Psychology Associate IIs and Psychology Assistants in the area of behavioral health services are required to participate in clinical supervision under the direction of a Psychologist II, Psychologist III, ADC Clinical Director or ADC Mental Health Program Manager, or designee.

1.4 Licensed Psychology Associate IIs not required by statute or licensure board will also be afforded supervision. Supervision schedules for licensed Psychology Associate IIs will include consideration of experience, training, and performance.

1.5 Mental Health Therapist means an individual who, at a minimum, meets the criteria for a behavioral health paraprofessional under A.A.C. R9-2-201.14, is employed within the ADC job classification of a Mental Health Therapist, and provides mental health services to offenders confined to ADC.

1.6 Mental Health Correctional Officers means an individual who meets the A.A.C. R9-2-201.14, behavioral health paraprofessional or A.A.C. R9-20-271 behavioral health technician and is employed by ADC within the Mental Health Program as a Mental Health Correctional Officer III or IV.

1.7 Supervision means face-to-face, videoconferencing or telephonic direction or oversight provided by a qualified individual to evaluate, guide and direct all behavioral health services, to include psycho-educational programming, to assist an unlicensed or licensed provider employed with ADC in increasing their necessary knowledge, skills, techniques and abilities needed to provide behavioral health services ethically, safely and competently.

2.0 Clinical supervision of each unlicensed Psychology Associate II, Psychology Assistants, unlicensed Mental Health Therapist or Mental Health Correctional Officer will be conducted in accordance with their respective boards or regulatory agencies:

2.1 Supervision may be in either a group or individual setting and may include debriefings in response to an incident, an emergency safety response.

3.0 Clinical supervision provided by the supervising Psychologist may include:

3.1 A review of current inmate mental health issues, mental health services, or records,

3.2 A discussion on recognizing and meeting the unique treatment needs of the inmates receiving services from ADC Mental Health staff,

3.3 A review and discussion of other topics that enhance the skills and knowledge of staff members,

3.3.1 All completed trainings will be documented on the following month's Clinical Training Log.

4.0 The Licensed Psychology Associate I or II or Psychologist will ensure that each MH Correctional Officer under their supervision:

4.1 Has at least six weeks (240 work hours) of behavioral health work experience and is able to demonstrate the skills and knowledge required and referenced in subsection c (below).

4.2 Without the skills and knowledge required and referenced in subsection c (below) will receive six weeks (240 work hours) of continuous onsite direction from a licensed Psychology Associate I or II or Psychologist, and

4.3 Is able to demonstrate the skills and knowledge necessary to:

4.3.1 Protect client rights in A.A.C. R9-20-203

4.3.2 Provide psychoeducation that promotes individual dignity, independence, individuality, strengths, privacy, and choice;

4.3.3 Recognize obvious symptoms of a mental disorder, personality disorder, or substance abuse;

4.3.4 Provide the services authorized by ADC specific to their position;

4.3.5 Meet the unique needs of the inmate client population;

4.3.6 Protect and maintain the confidentiality of client records and information within the ADC security setting;

4.3.7 Recognize and respect cultural differences;

4.3.8 Recognize, prevent, and respond to a situation in which a client:

4.3.8.1 May be a danger to self or a danger to others,

4.3.8.2 Behaves in an aggressive or destructive manner,

4.3.8.3 May be experiencing a crisis situation, or
4.3.8.4 May be experiencing a medical emergency;

4.3.9 Read and implement an inmate's correction and treatment plan;

4.3.10 Assist an inmate in accessing community services and resources, as required by the staff member's job duties;

4.3.11 Record and document client information;

4.3.12 Demonstrate ethical behavior, such as by respecting staff member and inmate/client boundaries and recognizing the inappropriateness of receiving items from inmates;

4.3.13 Identify types of medications commonly prescribed for mental disorders, personality disorders, and substance abuse and the common side effects and adverse reactions of the medications;

4.3.14 Recognize and respond to a fire, disaster, hazard, and medical or mental health emergency; and

4.3.15 Provide the activities or psychoeducation identified in the staff member's job description and within ADC Department Orders, Director's Instructions, Mental Health Technical Manual, and Mental Health Procedural Instructions.

4.4 Engage in and complete 12 hours of mental health oriented trainings during each subsequent year of service beyond their initial year of service. Such training would include:

4.4.1 Seminars, lectures, conferences, conventions, class work, teaching hours, and other professional meetings in which the content is geared towards:

4.4.2 Education on mental health issues and/or trends in the mental health field

4.4.3 Therapeutic interventions

4.4.4 Inmates' rights

4.4.5 Psychopharmacology

4.4.6 Issues specific to correctional mental health practices

4.4.7 All other issues approved by the Chief Psychologist.

4.5 All completed trainings will be documented on a Clinical Training Log.

Arizona Department of Corrections	Levels of Mental Health Services Delivery	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 1.0	Supersedes: Procedural Instruction TR0001 Effective Date: 8/15/11

Reference: Department Order 801
MHTM 4-5.0

Purpose: To provide a standardized system of inmate mental health need identification that is consistent with both established standards of Mental Health care and the mental health needs of incarcerated individuals.

Responsibility: It is the responsibility of the inmate's assigned mental health provider(s) on-unit to ensure that inmates with identified Mental Health Needs are provided services in accordance with the minimum level of service delivery outlined below.

The Arizona Department of Corrections Inmate Mental Health Classification Criteria should be referenced with regards to the qualifying criteria for each mental health score. This criterion can be found in Department Order 801.

1.0 Mental Health Service Delivery

1.1 **MENTAL HEALTH 3**

1.1.1 Inmates with Mental Health needs, who require current treatment.

1.1.2 Inmates meeting this criteria will be divided into three categories:

1.1.2.1 Category A: Inmates in acute distress who may require substantial intervention in order to remain stable. These inmates may need inpatient settings or specialized mental health programs to address their unique needs. (Example: A floridly psychotic or delusional inmate with current or frequent suicidal ideation, or currently under a PMRB.)

1.1.2.2 Category B: Inmates who may need regular intervention but are generally stable and participate with psychiatric and/or psychological interventions. (Example: An inmate with a major depressive or other affective disorder who benefits from routine contact with both psychiatry and psychology staff.)

1.1.2.3 Category C: Inmates who need infrequent intervention and have adequate coping skills to manage their mental illness effectively and independently. (Example: An inmate with a general mood or

anxiety disorder who has learned to manage their symptoms effectively through the use of medication and infrequent contact with mental health staff.)

1.1.2.4 A new treatment plan is developed for all Categories upon a mental health diagnosis given after assessment by Mental Health staff.

1.1.2.4.1 This treatment plan will be updated as the inmate's condition warrants.

1.1.2.5 A Mental Health Treatment Staffing as clinically indicated.

1.1.2.5.1 This staffing will be documented on a designated staffing note (Form #1103-69P)

1.1.2.6 Mental Health contacts a minimum of every ninety (90) days or more often as clinical indicated.

1.1.2.7 The inmate's Mental Health score may be changed as clinically indicated.

1.1.2.8 If housed in segregated housing (single cell) mental health contact a minimum of once every thirty (30) days or more often as clinically indicated.

1.1.2.8.1 If adequate staffing resources are not available to meet this standard, mental health staff shall triage cases based on clinical need of the population.

1.1.2.9 Inmate requires corridor placement unless Mental Health Staffing Review has specifically authorized non-corridor placement.

1.2 MENTAL HEALTH 0

1.2.1 Inmates who do not currently have Mental Health Needs and are not currently in treatment. These inmates will not be regularly monitored by mental health staff, but may request mental health services in accordance with the Health Needs Request protocols.

1.2.2 The inmate's Mental Health score and/or Category may be increased when clinically indicated based upon the treating clinician's assessment of the quality of the inmate's current functioning.

1.2.3 Inmates classified as MH0 must have demonstrated behavioral and psychological stability for at least six months and have had no medications targeting psychological symptoms for twelve months. Stability is defined as having had no significant self-harming events requiring immediate medical intervention. Superficial cutting or other pseudo-self-harming behaviors for attentional/housing needs shall be assessed on a case-by-case basis and may not require a classification of MH3.

1.2.4 Inmates with suicide attempt histories shall be evaluated on a case-by-case basis as well. Inmates with verified serious suicide attempts within the last three years shall not be classified as MH0.

1.3 SERIOUSLY MENTALLY ILL

1.3.1 All newly designated SMI inmates [as defined in MHTM 4-5.0] will:

1.3.1.1 Be designated a Mental Health 3A, B, or C..

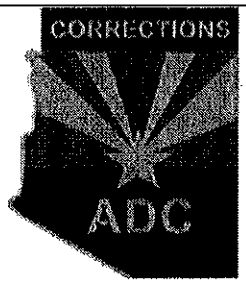
1.3.1.2 Have a treatment plan on file and reviewed as clinically necessary.

Attachment 2-1.0A

MH score	Treatment Plan	Records Reviews	MH score and Sub-code changes	Face-to-Face meetings
3 (See subcodes below)	Developed: Upon Diagnosis Reviewed: As the condition warrants	Initial: When referred to MH Follow up review: As Clinically Indicated	Evaluated: As clinically indicated. Changed: As clinically indicated	MH or Psychiatry staff: Every 90 days
	Subcodes are used like GAF scores. Subcodes can change at each interaction with the inmate as their condition warrants.			
Subcode A	Inmates in acute distress who may require substantial intervention in order to remain stable. These inmates may need inpatient settings or specialized mental health programs to address their unique needs. (Example: A floridly psychotic or delusional inmate with current or frequent suicidal ideation, or currently under a PMRB.)			
Subcode B	Inmates who may need regular intervention but are generally stable and participate with psychiatric and/or psychological interventions. (Example: An inmate with a major depressive or other affective disorder who benefits from routine contact with both psychiatry and psychology staff.)			
Subcode C	Inmates who need infrequent intervention and have adequate coping skills to manage their mental illness effectively and independently. (Example: An inmate with a general mood or anxiety disorder who has learned to manage their symptoms effectively through the use of medication and infrequent contact with mental health staff.)			
0	Developed only when the inmate is reclassified to MH-3	Initial: Once referred to MH Follow up review: As Clinically Indicated	Evaluated: As clinically indicated Changed: As clinically indicated	Unnecessary unless reclassified to MH-3

**Inmates on psychotropic medication will be seen by either the psychiatric registered nurse II or the psychiatrist or psychiatric nurse practitioner no less frequently than every 180 days.

†All MH-3s inmates, if transferred to segregated housing, will be seen by mental health clinician within 24 hours of the next business day and a minimum of once every (30) days or more often as clinically indicated thereafter.

 Arizona Department of Corrections	Movement of Mental Health Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 2.0	Supersedes: MHTM 10.0 Effective Date: 8/15/11

Purpose: To facilitate the timely transfer of inmates, in a manner consistent with their mental health needs.

Responsibility: This is a shared responsibility, with the sending and receiving complexes Primary Clinicians and Chief Psychologists accountable for sharing information with relevant staff members.

1.0 The Chief Psychologist, or designee, shall:
- 1.1 Call or E-mail the Central Office Male/Female Movement Corrections Officers IVs, or their designees, to confirm the receiving unit has a bed available on the desired unit.

2.0 Transfer to Specialized Mental Health Programs
- 2.1 Movement to and from specialized mental health programs (e.g., Alhambra Behavioral Health Treatment Facility, Men's Treatment Unit, , Step-Down, Behavioral Management Unit and Women's Treatment Unit) shall be requested by the Chief Psychologist, or designee, at the specialized mental health program.
- 2.2 These requests for movement to and from specialized mental health programs shall also be copied to relevant Offender Operations staff (e.g., Deputy Warden for Operations, Deputy Warden, Major, and Captain) and to the Facility Health Administrators at the sending and receiving complexes.

3.0 Transfers from Non-Corridor Complexes
- 3.1 Movement of inmates from non-corridor to corridor complexes (e.g., for placement on precautionary watch or because of a change in Mental Health score) shall be requested by the Chief Psychologist, or designee, responsible for the non-corridor complex.
- 3.2 These requests for movement from non-corridor to corridor complexes shall also be copied to relevant Offender Operations staff (e.g., Deputy Warden for Operations, Deputy Warden, Major, and Captain) and to the Facility Health Administrators at the non-corridor and corridor complexes.

Arizona Department of Corrections	Triage for Needs Requests at Receptions	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 3.0	Supersedes: Procedural Instruction TR0005 Effective Date: 8/15/11

Reference: Department Order 1101

Purpose: To provide direction regarding the assessment and immediacy of mental health issues submitted via Health Needs Requests [HNRs] at reception areas.

Responsibility: Staff triaging HNRs are responsible for making necessary referrals to health services personnel when appropriate. Mental Health personnel receiving referrals for services are responsibility to respond within the guidelines outlined in Department Order 1101.

1.0 Health Need Requests (HNRs) to Mental Health from Reception inmates will be reviewed by designated Mental Health clinician (excluding Psychiatrists and Psychiatric Nurse Practitioners).

2.0 Inmates with non-medication issues will be forwarded to appropriate Mental Health Staff (Psychologist, Psychology Assistant, Mental Health Therapist or Psychology Associate).

3.0 Inmates with urgent medication issues (e.g., serious medication side effects) will be seen by psychiatric nursing staff for assessment and triage.

4.0 Inmates with non-urgent medication issues will be referred to the psychiatric staff at their receiving facility. A mental health progress note will be completed by psychiatric nursing staff documenting this referral and will be placed in the mental health section of the inmate medical record.

4.1 "Non-urgent" by definition means issues for which the inmate can wait until he/she is seen at the receiving facility (e.g., initiating medications such as mood stabilizers, antidepressants, and antipsychotics, which may require several weeks to exert therapeutic impact so that waiting for the inmate to be seen by the psychiatric provider at the receiving complex is reasonable).

4.2 Insomnia

4.2.1 At reception, medications are NOT prescribed for sleep and will be neither continued nor initiated by the reception psychiatrist.

4.2.2 Reception inmates with a primary diagnosis of insomnia will be referred to a Mental Health clinician for alternatives to sleep medication.

4.2.2.1 Alternatives include coping/relaxation techniques, basic psycho-educational training in sleep hygiene, and referral to ancillary

interventions (e.g., sleep therapy group) at the receiving facility if available.

4.2.3 Insomnia as a symptom of another diagnosis will be addressed by treating that diagnosis (e.g., neuroleptics for schizophrenia, or antidepressants for affective disorders, etc.).

5.0 Special Handling inmates (who may have extended stays at Reception) will be referred to psychiatry for both urgent and routine psychiatry follow up care as deemed necessary by the psychiatric nursing staff triaging a submitted Health Needs Request (HNR).

Arizona Department of Corrections	Mental Health Assessment of Minors at Reception	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 4.0	Supersedes: MHTM 6.0 Effective Date: 8/15/11

Purpose: To outline protocols for the management and mental health services provision to Minor inmates charged to the custody of ADC.

Responsibility: Mental Health personnel operating in a Minor reception area are responsible for the mental health care needs of such inmates in accordance with the procedures identified in this section.

1.0 Procedure

1.1 Within two business days of every Minor inmate's arrival at a reception facility, the assigned Mental Health clinician shall meet with the minor inmate.

1.2 Mental Health staff shall conduct a clinical interview and an intellectual assessment to determine if mental health or substance abuse problems are present and may require intervention.

1.2.1 The clinical interview shall include a Mental Status exam.

1.2.2 The findings from the clinical interview and assessment shall be documented immediately in the Mental Health section of the minor inmates Medical File.

1.2.3 When appropriate, the Mental Health clinician shall promptly refer minor inmates to the Psychiatrist for assessment.

1.3 In the event that a psychological evaluation of a minor inmate has been conducted within (6) six months of reception and is available for immediate review, additional psychological testing shall be waived unless deemed necessary by the mental health clinician.

1.3.1 A note documenting this previous evaluation and briefly describing its findings shall be made in the Mental Health section of the Medical File.

1.3.2 A copy of the previous psychological evaluation shall be filed in the minor inmate's Medical File under PR(IOR) REC(ORDS)/REL(EASE) OF INFO(RMATION).

1.4 The Minor's Unit Psychologist II shall determine if additional testing is needed in the following areas:

1.4.1 Psychopathology

1.4.2 Personality functioning

1.4.3 Neuropsychological functioning

1.4.4 Intellectual functioning

1.5 The results of psychological testing shall be documented in the Mental Health section of the Medical File.

1.5.1 Psychological assessment reports shall include, at a minimum, identifying data, reason for referral, mental health history, current findings, and recommendations.

1.5.2 Reports of psychological testing may be documented either in a S.O.A.P. type note or in the form of a psychological assessment report.

1.5.3 Reports of any psychological testing shall be signed or counter-signed by a licensed Psychologist.

1.6 In the event that a minor inmate is non-English speaking, an accommodation will be made to conduct the interview and psychological testing in the minors' native language, to the extent feasible.

Arizona Department of Corrections	Health Planning Consultants	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 5.0	Supersedes: Effective Date: 8/15/11

Purpose: To provide guidelines regarding the Departments initiatives for preparing inmates to return to the community and ensure inmates receive Mental Health Re-entry Planning.

Responsibility: Health Planning Consultants are responsible for recording, identifying, and providing Mental Health re-entry services in accordance with this section.

1.0 Referrals for Re-entry Services
- 1.1 The Health Planning Consultant on complex will identify inmates who may potentially require mental health re-entry services by:
  - 1.1.1 Receiving a HNR or inmate letter from the inmate requesting services
  - 1.1.2 Referral from staff, to include but not limited to:
    - 1.1.2.1 Pharmacy
    - 1.1.2.2 Medical
    - 1.1.2.3 Mental Health
    - 1.1.2.4 Operations
    - 1.1.2.5 Programs
    - 1.1.2.6 Chaplains
  - 1.1.3 Maintaining and/or accessing databases that cross-reference the inmate population on complex against the eligibility criteria outlined in section 2.0 through 2.1.2.3 of this policy.

2.0 Eligibility Criteria for Mental Health Re-entry Services
- 2.1 To qualify for Mental Health re-entry services the inmate must have:
  - 2.1.1 Less than 180 days remaining on their sentence
  - 2.1.2 And at least one of the following three designations:
    - 2.1.2.1.1 Mental health score of 3 [regardless of subcode]
    - 2.1.2.2 Seriously Mentally Ill in ADC [SMI] designation
    - 2.1.2.3 Seriously Mentally Ill in the community [SMI/C] designation

3.0 Acceptance/Rejection/Refusal of Re-entry Services
- 3.1 Once a potential Mental Health re-entry inmate has been identified [regardless of referral or request] the inmate's case will be reviewed by the Health Planning Consultant to determine the appropriateness of the potential referral.

3.1.1 If the inmate meets the criteria outlined in section 2.0 through 2.1.2.3, the Health Planning Consultant will meet with the inmate and assess the his/her willingness to participate in re-entry services.

3.1.1.1 If the inmate accepts re-entry services the Health Planning Consultant will:

3.1.1.1.1 Outline the processes and services provided in Release planning.

3.1.1.1.2 Help the inmate to set realistic expectations of the types of services available in the community.

3.1.1.1.3 Assist the inmate with making a plan to address barriers to services in the community [e.g., saving money, obtaining documentation etc.].

3.1.1.2 If the inmate refuses re-entry services then he/she will be asked to sign the appropriate refusal of re-entry services form.

3.1.1.2.1 Both the inmate and Health Planning Consultant will retain a copy of this signed form and a copy will be added into the inmate's medical file.

3.2 If an inmate requests, or is referred for re-entry services, but is deemed not an appropriate referral by the Health Planning Consultant, the inmate will be notified in writing within (10) ten days via an inmate letter response outlining the rationale for the denial of re-entry services.

4.0 Re-entry Services

4.1 The Health Planning Consultant will offer to assist with the following:

4.1.1 AHCCCS application completion and submission.

4.1.1.1 AHCCCS applications require specific information and documentation that the inmate must be able to provide prior to receiving AHCCCS services.

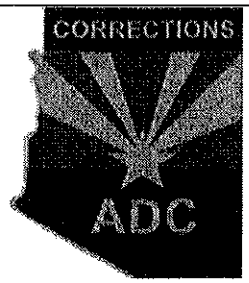
4.1.1.2 The application will need to be completed and returned to the Health Planning Consultant, with all relevant documentation and information, no later than 31 days prior to release.

4.1.1.2.1 The Health Planning Consultant may be able to assist with obtaining information and documentation on a case by case basis.

4.1.2 Referral to the Regional Behavior Health Authority [RBHA] if the inmate requires SMI services.

4.1.2.1 Every effort will be made to assure continuity of care and a smooth transition to mental health services in the community for inmates who have been determined by a psychiatrist or psychologist to be SMI in ADC.

4.1.3 All other services/resources/information the Health Planning Consultant has available and believes will be of benefit to the inmate once in the community.

 Arizona Department of Corrections	Double-Bunking Inmates on Watch	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 6.0	Supersedes: Effective Date: 8/15/11

Reference: Department Order 807

Purpose: To provide guidelines regarding the safety review, appropriateness, and mutual decision making process between security and mental health/health services staff regarding double-bunking inmate's while on ten-minute and thirty-minute watches.

Responsibility: It is the responsibility of the security shift commander and the on-duty mental health or health services staff member to assign double-bunked watches according to the criteria outlined below.

1.0 Inmates on a continuous watch shall not be double-bunked.

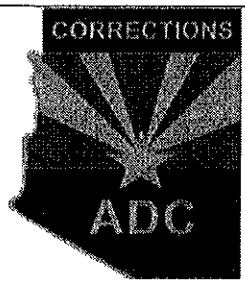
2.0 Inmates on a ten-minute or thirty-minute watch can be double-bunked according to the following criteria:

- 2.1 Inmates on a ten-minute or thirty-minute watch may only be double-bunked after a review of pertinent inmate data by security staff and a review of the mental health record by a mental health clinician has been completed.
- 2.2 Security and mental health staff shall consult one another regarding a decision to double-bunk inmates on a ten minute or thirty minute watch.
  - 2.2.1 If consensus between security and mental health/health services staff can not be reached, the inmate will be housed according to the policy and procedures outlined in Department Order 807.
- 2.3 Inmates shall never be double-bunked on a ten minute or thirty minute watch when there are overriding concerns about safety and security issues raised by either security or a mental health clinician.
- 2.4 Inmates will only be double-bunked if each inmate is within one custody level of each other.
  - 2.4.1 Inmates must also be on the same level of watch (i.e., a 10 minute watch with another 10 minute watch).
- 2.5 Inmates may be upgraded or downgraded into or from double-bunked watches in accordance with the entirety of this policy.
- 2.6 The decision to double-bunk inmates, and any conditions or changes [as noted above in 2.3 through 2.5], shall be documented in each inmate's medical file by the responding mental health clinician at the time of the event.

2.7 In the event the issue of double bunking two inmate's on watch arises during non-business hours, the following guidelines shall be followed:

2.7.1 The inmates shall be housed alone until such time as the Chief Psychologist, or designee, and assigned security staff are able to review all pertinent information.

2.7.2 Under no circumstances shall the On-Call Urgent Responder be contacted to address this situation. An On-Call Urgent Responder is not authorized to order the double-bunking of inmate's on any level of watch.

 Arizona Department of Corrections	Mental Health Follow-up After Discharge from Watch	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 7.0	Supersedes: Effective Date: 8/15/11

Reference: Department Order 807

Purpose: To provide direction regarding mental health service delivery and post watch follow-up for inmates being discharged from any level of mental health watch [i.e., continuous, ten minute, or thirty-minute].

Responsibility: It is the responsibility of the Chief Psychologist to ensure a mental health clinician provides any necessary follow-up services Mental health personnel on the receiving unit are responsible for providing the post watch follow-up until it is determined that an alternative follow-up schedule or discontinuance is clinically indicated.

1.0 Post watch follow-up for inmates being discharged from a ten minute or thirty minute watch will be conducted as follows:
- 1.1 If clinically indicated, post watch follow-up may be ordered by the mental health clinician discontinuing the watch.
- 1.2 The post watch follow-up order and the assessment of the inmate during post watch follow-up will be SOAP noted in the inmate's medical chart.

Arizona Department of Corrections	Transfer of Behaviorally and Mentally Disordered Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 8.0	Supersedes: Effective Date: 8/15/11

Purpose: To provide a standardized operational procedure regarding the transfer of behaviorally and mentally disordered inmates from ASPC-Phoenix mental health program units [e.g., Baker Ward and~~,~~ Flamenco Mental Health Center] to other facilities.

Responsibility: To coordinate between Alhambra and the receiving unit the transfer of the inmates to the designated outpatient facility.

Procedure:

1.0 The ASPC-Phoenix Chief Psychologist (or designee) shall:
- 1.1 Notify Central Office Movement OSB Administrator, via e-mail, of the inmate to be discharged.
- 1.2 Enter the necessary comments into AIMS regarding movement request
- 1.3 Remove any transfer holds if in place.

2.0 Central Office Movement Staff shall review the inmate and provide the requesting Chief Psychologist (or designee) with the designated housing location and scheduled date of transfer.

3.0 Upon completion of sections 1.0 through 2.0 of this section, the requesting Chief Psychologist ~~II~~ (or designee) shall notify the receiving unit.
- 3.1 This notification is to be made:
  - 3.1.1 Within one business day prior to the date of transfer;
  - 3.1.2 To the Chief Psychologist or a Psychologist II at the receiving complex;

4.0 And provide a clinical summary.

5.0 Central Office movement staff will:
- 5.1 Arrange transportation and schedule movement within 48 hours of notification
- 5.2 Inform the designated mental health staff at ASPC-Phoenix as well as the Chief Psychologist at the receiving unit of the scheduled date of transport.

Arizona Department of Corrections	Interstate Compact Consent for Mental Health Evaluation	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 2 Section 9.0	Supersedes: Effective Date: 8/15/11

Purpose: To provide direction for the use of mental health form (1103-40d); Consent for Release of Medical Information for Facilitation of Interstate Corrections Compact Transfer.

Responsibility: It is the responsibility of the Psychologist ~~II~~ completing the interstate compact request to comply with all points noted in the below policy. In addition, the Chief Psychologist shall ensure that all requests for psychological evaluation relating to interstate compact are completed.

7.0 Upon request from the Interstate Compact Coordinator, the Psychologist ~~II~~ assigned to the yard on which the potential Interstate Compact inmate is currently assigned will complete the required psychological evaluation as specified under the proposed interstate compact agreement.

8.0 Prior to the completion of any evaluation and/or testing the Psychologist ~~II~~ will instruct to the inmate to read and sign the Medical Information for Facilitation of Interstate Corrections Compact Transfer (form 1103-40d).

9.0 Once completed the Psychologist shall:

- 9.1 Send the originals of both the release of information (form 1103-40d) as well as the final psychological evaluation to the Interstate Compact Coordinator thought the internal mail system.
- 9.2 Ensures copies of all submitted materials related to the Interstate Compact have been filed in the inmate's medical chart under the legal tab.
- 9.3 Forward copies of all submitted materials related to the Interstate Compact to Central Office records to be filed in the inmate's institutional master file.

Arizona Department of Corrections	Men's Treatment Unit [MTU]	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 3 Section 1.0	Supersedes: MHTM 27.0 Effective Date: 8/15/11

Purpose: The Department operates the Men's Treatment Unit to provide Mental Health programming and housing to male inmates who demonstrate a mental disorder and who meet specific admission criteria. Mental Health programming at the facility shall include, but not be limited to, individual and group therapies.

Responsibility: The MTU Program Coordinator, in conjunction with the Chief Psychologist on complex, jointly carry the overall responsibility for the provision of mental health programming in accordance with the below outlined protocol.

1.0 Identified Program Contacts
- 1.1 The Facility Health Administrator shall have overall responsibility for MTU.
- 1.2 The Clinical Director, of the Alhambra Behavioral Health Treatment Facility [ABHTF] individually, or through the Chief Psychologist, or a designee, shall:
  - 1.2.1 Ensure that referrals for MTU admission are limited to those inmates who have:
    - 1.2.1.1 A Mental Disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders and supported by the inmate's medical/psychiatric history, family/social history, and/or psychological testing, or
    - 1.2.1.2 Those inmates who have limited functional ability as a result of being Seriously Mentally Ill (SMI), Brain Damaged, or Developmentally Disabled.
  - 1.2.2 Ensure that facility Mental Health professionals process referrals/admissions to the MTU in accordance with policy.
- 1.3 The MTU Mental Health Program Coordinator position will be filled by a Psychologist II, or other mental health clinician designated by the Clinical Director of ABHTF. This individual shall:
  - 1.3.1 Coordinate all activities related to the admission and discharge processes.
  - 1.3.2 Review all referrals to the MTU.
  - 1.3.3 Confer with the MTU treatment team following receipt of all documents.
  - 1.3.4 Notify Security of approved applicants.

2.0 MTU Admission Criteria

2.1 Inmates may be admitted to the MTU if they meet the following criteria:
- 2.1.1 The inmate exhibits emotional or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in general population without supportive treatment or services for a long-term or indefinite duration, as a direct result of having a Mental Disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders and supported by the inmate's medical/psychiatric history, family/social history, and/or psychological testing.
- 2.1.2 The inmate has a Mental Health Score of 3.
- 2.1.3 The inmate must accept MTU placement and treatment voluntarily.
- 2.1.4 Inmates considered for admission must have a Public Risk Score of 3 or lower and must have an Institutional Risk Score of 4 or lower.
  - 2.1.4.1 If an inmate's P/I scores are higher than 3/4, but the inmate is otherwise appropriate for MTU admission, an Administrative Reclassification will need to be completed by security/operations staff at the referring complex.
  - 2.1.4.2 The Reclassification Process shall continue during the inmate's MTU stay, with Classification Hearings conducted at 180-day intervals.

3.0 Denial of Admission to MTU

3.1 Inmate Admission to the MTU program may be denied if the inmate:
- 3.1.1 Has a sentence of more than 10 years, unless approved by the Aspen Deputy Warden after consultation with the complex Warden.
- 3.1.2 Has presented with violent or assaultive behavior during the previous year, as evidenced by a disciplinary action.
- 3.1.3 Has attempted/completed an escape from a secure perimeter facility less than three (3) years ago, or multiple such escapes/attempted escapes within the past ten (10) years.
- 3.1.4 Has a life sentence.
- 3.1.5 Has a history of active membership in a special threat group [STG].
- 3.1.6 Has not received a minor disciplinary ticket in the last 6 months, or a major disciplinary ticket in the last 12 months.
- 3.1.7 Has not been on any level of watch in the past 6 months.

4.0 MTU Admission Processes:

4.1 The process is intended to be a cooperative effort by the Mental Health clinician at MTU and the referring complex with the goal of informed, timely decision-making and admission of inmates with optimal potential to derive programmatic benefit.

4.2 Pre-Screening Process:
- 4.2.1 The Mental staff contact person at the referring facility will verify that the information contained in the Department's AIMS system is up-to-date, including Mental Health Score, SMI status, whether the inmate takes medication, and any informative comments.
- 4.2.2 Pre-screening Referral Packet
  - 4.2.2.1 The Mental Health clinical contact person at the referring facility will submit the Pre-screening Referral Packet to the MTU Mental

Health Program Coordinator. The Pre-Screening Referral Packet must include all (4) four of the following components:

4.2.2.1.1 Men's Treatment Unit General Referral Data (Form 1103-9P completed by MH staff from the referring complex.

4.2.2.1.2 MTU Contract signed by inmate.

4.2.2.1.3 Inmate Psychosocial History for completed by the Inmate.

4.2.2.1.4 Copies of Continuous Mental Health Progress Notes for a (2) two month period if the inmate has not been on any type of watch during the previous six (6) months, or Copies of Continuous Mental Health Progress Notes for a six (6) month period if the inmate has been on watch.

4.2.3 Pre-Screening Mental Health and Security Reviews

4.2.3.1 Upon receipt of the Pre-Screening Referral Packet, the MTU Mental Health Program Coordinator will review the packet, confer with other members of the MTU Mental Health staff as needed, and decide whether the referred inmate will be accepted into the MTU program

4.2.4 Pre-Screening Decision Notification

4.2.4.1 Within (5) five working days of receipt of the complete Pre-Screening Referral Packet, the MTU Mental Health Program Coordinator will notify the Mental Health clinical contact or Chief Psychologist at the referring facility of the Pre-Screening Decision.

4.2.4.2 The Pre-Screening Decision will be to accept inmate OR to deny admission

4.2.4.3 If the inmate is accepted, the MTU Mental Health Program Coordinator will notify the Classification Manager to determine if the inmate meets the Security screening requirements.

4.2.4.4 When the Classification Manager has determined that the inmate meets the Security criteria, the Classification Manager will arrange for inmate movement from the referring complex to MTU.

4.2.5 Notification of Pre-Screening Decision will be by telephone and by emailing or faxing completed Pre-Screening Decision Report.

5.0 MTU Discharge Criteria

5.1 Discharge of an inmate from the MTU may be initiated when an inmate meets any one of the following (5) criteria:

5.1.1 The inmate achieves a release date.

5.1.2 The inmate has completed the MTU Mental Health Treatment Plan, reached maximum treatment benefit, and is able to function in a general institutional environment.

5.1.3 The inmate fails to participate actively and in a positive fashion in the programming outlined in his MTU Mental Health Treatment Plan.

5.1.4 The inmate has exhibited behavior that threatens the safe and secure operation of the unit, the inmate's own personal safety, or the safety of others.

5.1.4.1 Such behaviors will be documented in accordance with Department Order 105 (Information Reporting) and Department Order 803 (Inmate Discipline System).

5.1.5 The inmate requests to end programming and transfer from MTU.

5.1.5.1 Such requests may be made by the inmate at the 180-day Classification Hearing or at the 180-day Mental Health Treatment Plan Review staffing.

6.0 Discharge Processes:

6.1 If the inmate is being released from the Department:

6.1.1 Pre-Release planning is initiated by the MTU Mental Health COIII assigned to MTU.

6.1.2 The Mental Health COIII is responsible for coordinating continuity of care services in the community.

6.1.3 The Mental Health COIII will arrange for evaluations, facilitate on-site interviews, and ensure appropriate documentation is provided.

6.1.4 The MTU Mental Health Program Coordinator or designee shall prepare a Continuity of Care Packet as needed.

6.2 If the inmate requests a transfer, the MTU Mental Health Program Coordinator, or designee, will meet with the inmate to determine the appropriateness of the inmate's request in light of the inmate's treatment plan. If the MTU Mental Health Program Coordinator, or designee, determines the request is appropriate, the Deputy Warden or Assistant Deputy Warden will be notified of the transfer request.

6.2.1 The MTU Mental Health Program Coordinator, or designee, will coordinate continuity of care for any MTU inmate approved for transfer to another ADC facility.

6.2.2 If the request for transfer is not appropriate [i.e., psychosis, danger to self or others, etc], the MTU Coordinator, or designee, will meet with the inmate to resolve issues prompting the request for transfer, and will monitor the inmate's progress at least weekly for a minimum of 30 days.

6.3 When an inmate has met any of the discharge criteria of Section 5.0 through 5.1.5.1:

6.3.1 The Associate Deputy Warden/Deputy Warden or designee shall notify the MTU Mental Health Program coordinator of the inmate's pending transfer or release date.

6.3.2 The MTU Mental Health Team shall review the inmate's medical record and make placement/programmatic recommendations to the Deputy Warden, the Assistant Deputy Warden or their respective designee.

6.3.3 The MTU Mental Health Program Coordinator, or a designee, will provide the receiving Chief Psychologist with a written treatment/discharge summary.

6.3.4 The Chief Psychologist may request a teleconference to discuss and review the inmate being considered for transfer.

6.3.5 The Chief Psychologist may request the participation of integrally involved complex staff who will be involved in successful transition to the new complex.

6.3.6 The Chief Psychologist will document the review, discussion and decision regarding the transfer to the new complex.

Arizona Department of Corrections	Step-Down Program	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 3 Section 2.0	Supersedes: MHTM 29.0 Effective Date: 8/15/11

Purpose: The Department operates a Step-down Program to provide mental health services and housing to male inmates who demonstrate an Axis I mental disorder and who meet specific admission criteria. Mental health programming shall include, but not be limited to, individual counseling, group therapy, and psychiatric services.

Responsibility: The Step-Down Program Coordinator, in conjunction with the Chief Psychologist on complex, jointly carry the overall responsibility for the provision of mental health programming in accordance with the below outlined protocol.

1.0 Referrals
- 1.1 Inmates may enter the step-down program from any point within the Department, if their P/I score is appropriate for the unit or they have an approved override, and they meet the admission criteria.

2.0 Admissions
- 2.1 The Chief Psychologist, or designee, will review each referral to the Step-down program to ensure the admission criteria have been met.
  - 2.1.1 Admission Criteria
    - 2.1.1.1 Inmates may be admitted to the Step-down program if they meet all the criteria listed below in 2.1.1.1.1 through 2.1.1.1.9.
      - 2.1.1.1.1 A mental disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders and supported by the inmate's medical/psychiatric history, family/social history and psychological testing.
      - 2.1.1.1.2 The inmate accepts placement and treatment voluntarily.
      - 2.1.1.1.3 The inmate has been compliant with all aspects of any ADC Mental Health programming he may have received thus far, e.g. medications, group participation, journal writing, etc.
      - 2.1.1.1.4 The inmate has P/I scores of 4/4 or lower.
      - 2.1.1.1.5 The inmate demonstrates motivation to maintain employment and/or educational programming.

2.1.1.1.6 The inmate demonstrates appropriate social interaction/behavior/self-care skills.
2.1.1.1.7 The inmate has received no disciplinary tickets for a minimum of 3 months.
2.1.1.1.8 There is a history of difficulty or failure in coping on an open yard due to Mental Health related issues.
2.1.1.1.9 The inmate demonstrates ability to manage behavior in his present environment without significant problems.

3.0 Review of Progress
3.1 Staffing for each inmate will be held every 4 weeks and will include reports from Mental Health, Programs, and Security. Progress reports will be provided by each representative and summarized in a progress note by the assigned MH staff. Any change in status will be determined at that time.

4.0 Dismissal from Program
4.1 Significant or repeated failure to demonstrate appropriate behaviors may result in an inmate being dismissed from the program. In the case where it is determined that an inmate's inappropriate behavior is due exclusively to his mental illness (i.e., decompensation) and not to antisocial traits/behaviors, that inmate may stay in the program, as determined by the assigned MH staff. Any return to the sending unit requires notification to the sending unit of the reasons for dismissal. The inmate's Mental Health Score will be changed to reflect any change in his Mental Health functioning and status.

5.0 Jobs
5.1 Step-down inmates will be provided jobs on the Rincon Unit as available. The WIPP coordinator will meet with each Step-Down inmate to provide skills assessments and determine placement in the most appropriate job. All inmates will be held fully accountable for their job performance and will be subject to dismissal from that job the same as would a general population inmate. Furthermore, if an inmate is dismissed from a job it may lead to dismissal from the Step Down program altogether. Each case would be reviewed for any special circumstances.

6.0 Meals and Outside Recreation
6.1 The Step-Down inmates will initially attend meals and recreation with inmates in the same housing unit, with the possibility of designating other times for these activities if this proves to be problematic.

7.0 Program Completion
7.1 Success in the program will be achieved when an inmate has maintained appropriate behaviors, for a period of not less than 60 days, in the following areas: employment, recreation, security requirements, group counseling, meals, personal care and hygiene, health care (including medications), housing/cooperative living, and programming.
7.1.1 Upon completion of the program, generally 180 days, an inmate will either integrate into the yard or be transferred to another open yard, or;
7.1.2 Where an inmate in the program has been determined to be a good candidate for the MTU program, he may remain in the step-down program until the time of his next reclassification (in order to meet the

classification requirements of MTU). Prior to his next classification hearing, however, the inmate's records will be forwarded to MTU admissions for their review and determination. or;

7.1.3 Where there is an inmate who has made sufficient progress in the 180 days of Step-down to suggest he can be successful on an open yard, but would benefit from a brief extension in the Step-down program, that inmate may be granted a brief extension in the program (up to 4 weeks) to be maximally prepared for such a transition.

Arizona Department of Corrections	Women's Treatment Unit [WTU]	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 3 Section 3.0	Supersedes: MHTM 26.0 Effective Date: 8/15/11

Purpose: The Department operates the Women's Treatment Unit [WTU] to provide Mental Health services and housing to female inmates who demonstrate a mental disorder and who meet specific Mental Health program admission criteria. Mental Health programming at the facility shall include, but not be limited to, individual and group therapies.

Responsibilities: The WTU Program Coordinator, in conjunction with the Chief Psychologist on complex, jointly carry the overall responsibility for the provision of mental health programming in accordance with the below outlined protocol.

1.0 WOMEN'S TREATMENT UNIT
- 1.1 The WTU Treatment Team Coordinator shall:
  - 1.1.1 Review all referrals to the WTU.
  - 1.1.2 Coordinate all activities related to WTU admission and discharge processes.

2.0 Criteria for Admission to WTU
- 2.1 Inmates may be admitted to the WTU if they meet the following criteria:
  - 2.1.1 The inmate has difficulty functioning in the general inmate population as a direct result of having a Mental Disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders and supported by the inmate's medical/psychiatric history, family/social history, and/or psychological testing.
  - 2.1.2 The inmate accepts WTU placement and treatment voluntarily.
  - 2.1.3 Inmate is medium custody (P/I score) of 3/3 and below.
  - 2.1.4 Inmate has a Mental Health score of MH 3.
    - 2.1.4.1 The WTU coordinator may accept referrals to the program that have a MH score of MH 0 on a case by case basis.

3.0 Criteria for Denial of Admission
- 3.1 An inmate may be denied admission to WTU if the inmate has:
  - 3.1.1 Any major disciplinary infractions for assaultive, violent behavior during the previous six (6) months.
  - 3.1.2 An active affiliation in a Security Threat Group affiliation during the past five (5) years.
  - 3.1.3 A custody (P/I score) of 4/4 or higher.

4.0 Admission Processes
- 4.1 Referral Screening
  - 4.1.1 A Multi-Disciplinary Committee made up of Perryville Mental Health Team reviews all referrals to WTU and makes decisions on which inmates will be admitted to this program.
  - 4.1.2 This committee is chaired by the WTU's Treatment Team Coordinator.

5.0 Referral process
- 5.1 A Referral Packet will be sent to the WTU's Treatment Team Coordinator for review.
  - 5.1.1 The Referral Packet will include:
    - 5.1.1.1 A Personality Assessment Inventory [PAI]
    - 5.1.1.2 Psychosocial History Questionnaire
    - 5.1.1.3 Mental Health Progress Notes for a minimum of (3) month period.

6.0 Review of the Referral Packet
- 6.1 Upon receipt of the Referral Packet, the WTU Treatment Team Coordinator will convene a Multi-Disciplinary Committee within (10) ten working days to review the Referral Packet and make a recommendation as to accept or reject the referral and notify the inmate of the decision.
- 6.2 WTU's Mental Health Program Coordinator will document the Multi-disciplinary team decision in the inmate's medical chart wherein reasons for a referral's rejection will be clearly stated on the Clinical Summary and Recommendations (Form 1103-69).

7.0 Movement to WTU
- 7.1 The WTU Coordinator shall notify Movement requesting the inmate to be transferred to the WTU program.

8.0 Discharge Criteria
- 8.1 The discharge of an inmate from the WTU shall be initiated when an inmate meets any of the following criteria:
  - 8.1.1 The inmate has a pending release date.
  - 8.1.2 The inmate has reached maximum treatment benefit and is able to function in a general institutional environment.
  - 8.1.3 The inmate fails to participate actively and in a positive fashion in programming prescribed by her WTU Treatment Plan.
  - 8.1.4 The inmate has exhibited behavior that threatens the safe and secure operation of the area, the inmate's own personal safety, or the safety of others.
  - 8.1.5 The inmate requests transfer from the WTU.

9.0 Discharge Processes
- 9.1 When an inmate has met any of the Discharge Criterion in Section 8.0 through 8.1.5 the inmate's CO-III shall notify the WTU Treatment Team Coordinator of the inmate's pending release date or transfer.
  - 9.1.1 WTU's Treatment Team Coordinator, or designee, shall contact the Mental Health clinician at the receiving facility/unit to coordinate continuity of care of any WTU inmates approved for transfer to another facility.

Arizona Department of Corrections	The Behavioral Management Unit [BMU]	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 3 Section 4.0	Supersedes: Effective Date: 8/15/11

Purpose: To provide direction regarding the intake, admission, treatment and discharge processes for the Behavioral Management Unit [BMU] located at ASPC- Eyman.

Responsibility: The Chief Psychologist at ASPC- Eyman, as exercised through the Psychologist II, or designee, shall facilitate the processes outlined in this policy.

1.0 Admission Criteria
- 1.1 To be admitted to the BMU program an inmate must:
  - 1.1.1 Have an Axis II diagnosis as defined in the current version of the Diagnostic and Statistical Manual of Mental Disorders.
    - 1.1.1.1 If an Axis I diagnosis is present, it must be well controlled through the use of psychotropic medications.
  - 1.1.2 Be expected to benefit from the programmatic elements offered.
  - 1.1.3 Require increased security and supervision.
  - 1.1.4 Have a history of problematic adjustment to incarceration.
  - 1.1.5 Have a persistent and on going inability to self-regulate assaultive, destructive and/or self-injurious behaviors.
- 1.2 Referral Process
  - 1.2.1 If it appears clinically indicated that an inmate meets the criteria outlined in section 1.0 through 1.1.5 of this section, the initiating referral will be made by the Chief Psychologist (or designee) at the sending unit.
  - 1.2.2 Referrals to the BMU made by the sending complex mental health staff shall be reviewed by the BMU program coordinator for acceptance into the program.

2.0 Behavior Planning
- 2.1 Each inmate admitted to the BMU will, after a face to face interview with mental health staff, receive an individualized behavior plan that addresses:
  - 2.1.1 The inmate's mental health problems, and
  - 2.1.2 Establishes realistic goals specific to ~~their~~ management of the inmate's behavior.
- 2.2 Each behavioral plan will be reviewed quarterly and reflect:

2.2.1 Progress made towards the identified goals.

3.0 Behavioral Interventions

3.1 Each inmate assigned to the BMU will be provided individualized and/or group treatment which addresses the inmate's identified behavioral health problems.

3.1.1 The frequency and duration of which will be determined by the licensed mental health professional assigned to the care of the inmate.

3.1.2 Recommendation for the inmate to move to another phase of treatment with in BMU [either up or down] is made on a continual basis.

4.0 Action Response for Regressive Behaviors

4.1 Clinically indicated behavioral interventions will be ordered by the mental health professionals assigned to the BMU to encourage an inmate's continued motivation and improvement regarding behavioral health symptomotology.

4.2 During each regressive event the mental health professionals will meet with and discuss with the inmate the need to improve their behavior according to their identified goals.

4.2.1 During this meeting the inmate will be provided with a description of conditions and time frames of expected behaviors and shall be documented in the inmate's medical charts.

5.0 Program Discharge

5.1 Upon completion of the BMU program the inmate will receive a certification of completion and, be officially discharged from the Program.

6.0 Correctional Security Responsibilities

6.1 Correctional security will:

6.1.1 Provide for maintenance of personal safety for staff and inmates.

6.1.2 Provide restraints as necessary in all movement to and from cells.

6.1.3 Supervise individual and group sessions as necessary.

6.1.4 Promote non-violent problem resolution.

6.1.5 Share confidential inmate information with other officers only on a 'need to know basis.'

6.1.6 Observe confidentiality consistent with Health Services and Department Standards.

Arizona Department of Corrections	Mental Health 14 Day Assessment	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 1.0	Supersedes: MHTM 5.0 Effective Date: 8/15/11

Purpose: This procedure is to ensure that all inmates, upon their arrival in the Arizona Department of Corrections, have a Mental Health Assessment completed. This assessment will be used to assist in decisions regarding classification, placement and need level for further Mental Health services and/or programming.

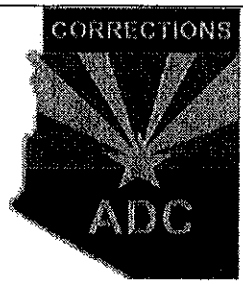
Responsibility: Mental Health staff assigned to the Alhambra and Perryville reception centers specifically, as well as Mental Health staff at all complexes where inmates are received directly from county, federal or other facilities are responsible to assess and determine individual mental health needs.

1.0 Procedure

1.1 Within fourteen days of an inmate's arrival at the Arizona Department of Corrections, a Mental Health professional will evaluate the inmate and complete a 14 Day Assessment (Form 1103-27P).

1.2 The completed assessment will be placed in the inmate's Medical Record, under the Problem List.

1.3 If an inmate does not receive the Assessment at the Reception Center, the receiving facility will complete the Assessment within the allotted time.

 Arizona Department of Corrections	Mental Health Consent to Treatment	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 2.0	Supersedes: MHTM 13.0 Effective Date: 8/15/11

Purpose: To ensure that every inmate who participates in Mental Health Treatment understands the limits of confidentiality, the alternatives, advantages, disadvantages, and potential risks and benefits to the treatment for which he/she is providing consent.

Responsibility: The assigned Mental Health clinician is responsible for explaining the limits of confidentiality and the effect(s) it may have on patient mental health care.

1.0 Procedure

1.1 All inmates participating in ongoing Mental Health Treatment, defined as greater than two sessions (other than emergency or involuntary treatment as defined in Department Order 1103), and all inmates participating in mental health group treatment, will be advised of the following:

1.1.1 Limits of confidentiality within the Arizona Department of Corrections, specific to:

1.1.1.1 Threats of harm to self or others.

1.1.1.2 Threats to the safe secure and orderly function of the institution (e.g., escape, disturbances, drug trafficking).

1.1.1.3 Information related to abuse, neglect or molestation of a minor, vulnerable or developmentally disabled adult, or elder adult.

1.1.1.4 Legal proceedings that requires that records be opened/released pursuant to state statute or a court order.

1.1.1.5 Discussion of a supervisory or treatment planning nature among Inmate Health Services staff.

1.1.1.6 Information related to an unsolved capital offense (e.g. unsolved murder)

1.1.2 Alternatives to proposed treatment.

1.1.3 Advantages and benefits of proposed treatment.

1.1.4 Disadvantages and risks of proposed treatment.

1.2 The inmate will be required to sign the Mental Health Treatment Consent (Form 1103-18).

1.2.1 If the proposed treatment is medication, the psychiatric provider will have the inmate sign the appropriate Psychiatric Medication Informed Consent Form.

1.3 The treatment provider and witnesses (as required) will sign the form at the time of the inmate's consent.

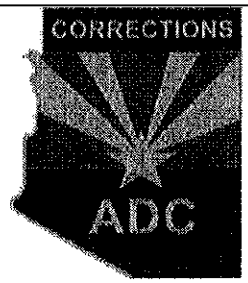
2.0 If an inmate refuses to sign the Mental Health Consent Form, the content of the form must be read and explained to the inmate (with another staff member as a witness) to ensure that the inmate's questions have been answered.

2.1 On the inmate signature line, write "refused to sign."

2.2 Place your signature on the Mental Health Staff signature line, your position, date and printed name/name stamp.

2.3 Below this have the witness place signature, position, date and printed name/name stamp.

2.4 After verbal presentation of the Consent form, and signatures completed, proceed to see the inmate unless s/he is refusing to be seen.

 Arizona Department of Corrections	Significant Self Harm Reporting	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 3.0	Supersedes: Procedural Instruction SP0001 Effective Date: 8/15/11

Purpose: To provide a standard protocol for reporting relevant mental health information pertaining to the inmate's self harm. The below protocols outline the flow of information from the complex where the self harm occurred to Central Office staff for the purposes of quality assurance, statistical analysis, and executive update.

Responsibility: The Chief Psychologists carries the overall responsibility for ensuring that Significant Self Harm [SSH] reporting is completed in accordance with the protocols of this section.

1.0 The Chief Psychologist, or designee, shall ensure a report is prepared for each significant inmate self-harm event occurring in his/her areas of responsibility. Significant self-harm events are defined as:
- 1.1 Events involving potentially lethal methods (e.g., hanging, overdose involving lethal substances, cutting, strangulation, etc).
- 1.2 Events involving methods that were likely to be lethal considering time of day, setting, or degree of staff supervision (e.g., cutting occurring in the middle of the night).
- 1.3 Any self-harm event resulting in medical hospitalization, to include medical services provided at an emergency room or other off complex medical unit.

2.0 Professional judgment and review of other institutional data may be necessary to make this determination.

3.0 Reports on significant self-harm events shall be completed utilizing the current Significant Self Harm Reporting Form.

4.0 Reports on significant self-harm events shall be forwarded to both the Complex Facility Health Administrator and the Mental Health Quality Assurance Coordinator at Central Office within ten (10) working days from the date of the self-harm event. This turnaround time does not preclude the Chief Psychologist, or designee, from making any interim procedural changes that may be necessary to ensure inmate health and safety.

5.0 The Chief Psychologist, or designee, will review all significant self-harm reports quarterly to identify units, areas on complex, or other concerns that could represent additional and/or future potential for significant self harm events. Any identified concern should be promptly brought to the attention of the Mental Health Program Manager, or designee, for possible policy/procedural change throughout the Department.

6.0 The Chief Psychologist, or designee, shall ensure a report is prepared for each significant inmate self-harm event occurring in his/her areas of responsibility. Significant self-harm events are defined as:

6.1 Events involving potentially lethal methods (e.g., hanging, overdose involving lethal substances, cutting, strangulation, etc).

6.2 Events involving methods that were likely to be lethal considering time of day, setting, or degree of staff supervision (e.g., cutting occurring in the middle of the night).

6.3 Any self-harm event resulting in medical hospitalization, to include medical services provided at an emergency room or other off complex medical unit.

7.0 Professional judgment and review of other institutional data may be necessary to make this determination.

Arizona Department of Corrections	Outpatient Mental Health Treatment Plans	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 4.0	Supersedes: MHTM 14.0 Effective Date: 8/15/11

Reference: MHTM 2-1.0, NCCHC Standard MH-G-03

Purpose: To ensure that each inmate with a clinically indicated need [as defined in Section 1.1 of this policy] has a written Outpatient Mental Health Treatment Plan (Form 1103-16p) based on an assessment of their clinical needs.

Responsibility: The Chief Psychologist at each complex has oversight responsibility in ensuring that inmates who meet the aforementioned criteria have a complete, current treatment plan in the inmate's medical file.

1.0 Procedure

1.1 Inmates with a Mental Health score of 3 shall have a treatment plan.

1.2 A treatment plan will be developed upon a diagnosis being given and added into their medical file.

1.2.1 All mental health treatment plans will be "floated" on top of the MH section of the inmate's medical chart, under the mental health divider with the most recent treatment plan on top.

1.2.2 The MH staff member who is responsible for the inmate's mental health care shall complete and update, as clinically indicated, the treatment plan.

1.2.2.1 The mental health provider and/or treatment team on the inmate's unit will review, name stamp and date the bottom of the plan.

1.2.2.2 The inmate may attend and participate in the plan if feasible

Arizona Department of Corrections	Determination and Management of Seriously Mentally Ill [SMI] Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 5.0	Supersedes: Procedural Instruction TR0002 Effective Date: 8/15/11

Reference: MHTM 2-1.0
MHTM 2-5.0

Purpose: To provide a standardized system of identifying inmates who do or do not possess SMI needs while incarcerated in ADC.

Responsibility: It is the responsibility of each licensed mental health professional to administer the SMI Determination Form when clinically indicated in accordance with this policy.

1.0 Definition
- 1.1 Seriously Mentally Ill inmates are those who:
  - 1.1.1 According to a licensed mental health professional possess:
    - 1.1.1.1 A qualifying mental health diagnosis as indicated on the SMI Determination Form.
    - 1.1.1.2 A severe functional impairment directly relating to their mental illness as indicated on the SMI Determination Form.
    - 1.1.1.3 A Mental Health score of 3.

2.0 SMI Status Conditions
- 2.1 An inmate will be denied the SMI in ADC designation if he/she fails to satisfy all the criteria identified in Section 1.1 through 1.1.1.3, but shall receive an additional SMI screening as clinically indicated.
- 2.2 Inmates previously determined to be SMI in the community mental health system shall have a new SMI Determination Form completed, as to ensure that the inmate meets the criteria specified in Section 1.1 through 1.1.1.3.
  - 2.2.1 The inmate will not be assigned a SMI in ADC qualifier based solely on his/her SMI status in the community.
- 2.3 Minimum mental health service delivery levels for SMI inmates will be determined by the inmate's mental health score and subcode in accordance with MHTM 2-1.0.
  - 2.3.1 Mental health need levels are independent of an inmate's designation as SMI, as SMI inmates can be considered to be stable in treatment or not.

3.0 SMI Identification
- 3.1 The inmate's medical file shall be brown-tagged to identify the inmate as SMI.

3.2 The designation "SMI" shall be placed on the Problem List in Section (1) one of the inmate medical record.

3.3 Designations of both SMI in ADC [SMI] and SMI in the community [SMI/C] shall be recorded on the DI 85 screen of AIMS.

3.4 SMI inmates shall be exempt from medical and mental health charges.

3.5 SMI inmates shall be referred to community mental health agencies for evaluation prior to release to ensure continuity of mental health care services for SMI inmates in accordance with MHTM 2-5.0

Arizona Department of Corrections	Psychological Autopsy	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 4 Section 6.0	Supersedes: Effective Date: 8/15/11

Reference: Department Order 1103
Department Order 1105

Purpose: As defined in DO 1105, a psychological autopsy will be completed on each inmate suicide. A psychological autopsy is the retrospective review document of an inmate's life with an emphasis on factors which may have contributed to the inmate causing his/her own death. The psychological autopsy has five potential purposes:

- To assist medical personnel in determining the inmate's mode of death in cases where the cause of death is equivocal.
- To provide a clear understanding of the inmate's state of mind prior to death.
- To provide a written account of collateral information provided by inmate and staff first responders, fellow inmates who were friendly with the deceased, and family members.
- To provide insights regarding how best to address the clinical needs of future suicidal inmates.
- To identify deficiencies in institutional policies and procedures.

Responsibility: It is the responsibility of the Mental Health Program Manager to have a psychological autopsy completed on each inmate suicide. It is the responsibility of the Chief Psychologist to conduct a psychological autopsy within twenty-nine (29) days for each suicide that occurs at their facility. In the absence of the Chief Psychologist the Clinical Director [ASPC-Phoenix] shall conduct the psychological autopsy.

Procedure:

1.1 Psychological Autopsy Committee [PAC] - Upon notification of an inmate suicide, the Chief Psychologist has fourteen (14) days to convene this committee.

1.1.1 The PAC shall:

1.1.1.1 Consist of the Facility Healthcare Administrator, Unit Deputy Warden, Mental Health Program Manager, Director of Psychiatry, and any additional staff that the Chief Psychologist deems pertinent.

1.1.1.2 Review the inmate's Medical/Mental Health record, including autopsy and toxicology reports.

1.1.1.3 Review any relevant source of data (e.g., information Reports, investigation reports, and Department documents, etc.) relevant to the incident.

1.1.1.3.1 The Chief Psychologist shall ensure that all relevant documents are available for review at the PAC.

1.1.1.4 Make recommendations concerning policy or procedural changes, as necessary, to the Chief Psychologist for consideration and inclusion in the Psychological Autopsy.

1.1.2 The Chief Psychologist shall compose the information listed in 1.1.1.1 through 1.1.1.4 of this section into the psychological autopsy.

1.1.3 The Chief Psychologist will submit the psychological autopsy to the Mental Health Program Manager within 29 days of the inmate's suicide.

1.1.4 The Mental Health Program Manager shall:

1.1.4.1 Ensure that the inmate suicide has been entered into the Serious Self Harm database.

1.1.4.2 Review the psychological autopsy report with the Medical Program Manager and Division Director of Health Services, or there respective designees.

1.1.4.3 Recommend any administrative or corrective action, if required.

1.1.5 The Health Services Division Director, or designee, shall forward the final psychological autopsy to the Division Director of Program Services, or designee.

Arizona Department of Corrections	Non-Formulary Requests for Psychiatric Medications	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 1.0	Supersedes: Procedural Instructions P0004 Effective Date: 8/15/11

Purpose: To outline the processes for Non-Formulary Request [NFR] for medications.

Responsibility: It is the responsibility of the medical/mental health clinician ordering NFR medications to act in accordance with this section.

1.0 All Non-formulary requests for psychiatric medications (Form 1103-25) shall be sent to the complex pharmacy for review.

2.0 The Pharmacist designated by the Division Director of Health Services and the Director of Psychiatry, or designee, shall review and approve or disapprove the NFRs.

3.0 In the absence of adequate substantiating data, NFRs for psychotropic medications will be denied, with the NFR form being returned to the prescribing psychiatrist /psychiatric nurse practitioner with a request for more information.

Arizona Department of Corrections	Psychiatric Prescription Duration	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 2.0	Supersedes: Procedural Instruction P0008 Effective Date: 8/15/11

Purpose: To outline the processes and timelines under which a prescription for psychiatric medications can be authorized.

Responsibility: The psychiatric provider is responsible for acting in compliance with the prescription writing processes outlined in this section.

1.0 Prescriptions for medication by psychiatrists or psychiatric nurse practitioners may be written for duration of up to 6 months.

2.0 For inmates on multiple medications, when the provider changes the dosage of one medicine the new expiration date should match the expiration date of the other previously written medications. The other medications which are not being changed do not need to be rewritten until approaching their expiration date.

3.0 Prescriptions for release medication by psychiatrists and psychiatric nurse practitioners may be written for a period of time not to exceed (30) thirty days.

4.0 Controlled substances (e.g., benzodiazepines, psychostimulants) are not covered by this instruction.

Arizona Department of Corrections	Psychiatric Registered Nurse II Interim Follow-up	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 3.0	Supersedes: Procedural Instruction P0009 Effective Date: 8/15/11

Purpose: To outline the procedures under which a psychiatric provider may order a Psychiatric Registered Nurse II to review the inmate's medical condition.

Responsibility: The PRN II is responsible to conduct the ordered assessment in accordance with the protocols outlined in this section.

1.0 The psychiatrist/psychiatric nurse practitioner may order a formal follow-up of inmates by the PRN II.

2.0 The PRN II will assess the inmate within the time frame designated in the order written by the psychiatrist/psychiatric nurse practitioner. The PRN II may also see inmates without a psychiatrist/psychiatric nurse practitioner order as clinically indicated. These assessments shall include a review of:
- 2.1 Current symptoms
- 2.2 Response to medications
- 2.3 Presence or absence of side effects
- 2.4 Safety issues (danger to self or others, ability to function in current environment).

3.0 If an adjustment in medication may be indicated, either by poor response to treatment or by the presence of adverse effects, the PRN II will staff the inmate's case with the treating psychiatrist/psychiatric nurse practitioner.

4.0 If the treating psychiatrist/psychiatric nurse practitioner is not available and the matter is urgent, the PRN II will staff the inmate's case with another available psychiatrist/ psychiatric nurse practitioner or the Urgent Response Psychiatrist/Psychiatric Nurse Practitioner.

5.0 If as a result of the assessment the PRN II determines that the inmate requires immediate placement on a continuous, ten minute or thirty minute watch for safety reasons, the PRN II will initiate the appropriate watch.

6.0 The PRN II will document the inmate contact and any staffing with the psychiatrist/psychiatric nurse practitioner in the mental health progress notes of the inmate medical record.

7.0 If the inmate is stable and requires no change in medications, the inmate will follow-up with the Psychiatrist/Psychiatric Nurse Practitioner as previously ordered. The PRN II

may provide additional interim follow-up with the inmate prior to the inmate's next contact with the Psychiatrist/Psychiatric Nurse Practitioner.

8.0 If clinically indicated, the PRN II may also schedule the inmate to see the Psychiatrist/Psychiatric Nurse Practitioner earlier than previously ordered. Staffing with the Psychiatrist/Psychiatric Nurse Practitioner is not necessary for the PRN II to schedule an earlier follow-up appointment with the provider.

9.0 PRN II will document their assessment of the inmate on the Psychiatric Nursing Follow-up note (Form 1103-50).

Arizona Department of Corrections	Depot Conventional Antipsychotic Medication	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 4.0	Supersedes: Procedural Instruction P0010 Effective Date: 8/15/11

Purpose: To identify the specific processes regarding depot antipsychotic medications.

Responsibility: The psychiatric provider [or other provider as necessary] shall dispense antipsychotic medications in accordance with the protocols outlined in this section.

1.0 Haloperidol decanoate and fluphenazine decanoate shall be prescribed in consideration of and in compliance with the medication package inserts.

2.0 Haloperidol decanoate shall only be used in inmates who have recently (within the past 30 days) demonstrated tolerance to haloperidol (oral liquid and tablets or IM injections).

3.0 Fluphenazine decanoate shall only be used in inmates who have recently (within the past 30 days) demonstrated tolerance to fluphenazine hydrochloride.

4.0 The initial target dose of haloperidol decanoate shall be based on the tolerated daily dose of oral or short acting injectable haloperidol.

5.0 The initial dose of haloperidol decanoate given every four weeks shall be no more than ten to fifteen times the daily dose of oral haloperidol.

6.0 If the inmate was receiving short acting injectable haloperidol the dose of haloperidol decanoate given every four weeks shall be no more than twenty to thirty times the daily dose of short acting injectable haloperidol.

7.0 The initial target dose of fluphenazine decanoate shall be based on the tolerated daily dose of fluphenazine hydrochloride.

8.0 Twenty milligrams of oral fluphenazine hydrochloride daily shall be considered equivalent to one milliliter (25mg) of fluphenazine decanoate injected every two weeks.

9.0 Ten milligrams of intramuscular fluphenazine hydrochloride daily shall be considered equivalent to one milliliter (25mg) of fluphenazine decanoate injected every two weeks.

10.0 Increases in the dose of depot medication shall only occur after the inmate has demonstrated an ability to tolerate an increased dose of short acting medication.

Arizona Department of Corrections	Continuation of Psychiatric Medications in Arriving Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 5.0	Supersedes: Procedural Instructions P0014 Effective Date: 8/15/11

Purpose: To provide direction regarding the processes under which an inmate's psychiatric medication may be continued upon arrival at ADC.

Responsibility: It is the responsibility of the psychiatric provider to continue psychiatric medications for inmates new to ADC custody in accordance with the protocols of this section.

1.0 For Alhambra Reception Treatment Center and Perryville reception inmates who are not seen by the psychiatrist or psychiatric nurse practitioner (P/PNP):
- 1.1 Medications can be continued on inmates who are not seen, provided that the PRN II has verified that the inmate is currently taking the medications through one of the following:
  - 1.1.1 Receipt of a continuity of care form from the referring facility, or
  - 1.1.2 Documentation from a pharmacy, or
  - 1.1.3 Current, properly labeled prescription bottles,
  - 1.1.4 Verification with outside medical records.
- 1.2 The prescribing P/PNP shall mark an asterisk in the upper left corner of the prescription to indicate that the inmate was not seen and that the PRN II has properly verified that the inmate is currently taking the medications ordered.
- 1.3 All medications, including those which are non-formulary (excluding controlled substances), can be continued for up to 90 days without a non-formulary request.
- 1.4 The prescribing provider shall order no more than the maximum dosage recommended by the FDA for any medication regardless of the amount the inmate was formerly receiving. Reducing the dose in this manner will not require a non-formulary request.
- 1.5 The PRN II shall attach a copy of the means of verification to the prescription sent to the ADC pharmacy.

2.0 For ARTC and PV reception inmates who are seen by the P/PNP:
- 2.1 Non-formulary medications can be continued on inmates who are seen, without a non-formulary request, provided that the PRN II has verified that the inmate is currently taking the medications through one of the following:
  - 2.1.1 Receipt of a continuity of care form from the referring facility, or
  - 2.1.2 Documentation from a pharmacy, or
  - 2.1.3 Current, properly labeled prescription bottles, or

2.1.4 Verification with outside medical records.

2.2 The medications can be continued at the same or reduced dosage for up to 90 days. Reducing the dose will not require a non-formulary request. Prescription duration in excess of 90 days will require a non-formulary request form be completed.

2.3 The prescribing provider shall order no more than the maximum dosage recommended by the FDA for any medication regardless of the amount the inmate was formerly receiving.

2.4 Increasing the dose of a non-formulary medication above that specified on the verifying documentation acquired by the PRN II will require the completion of a Psychiatric Non-Formulary Request (Form 1103-25).

2.5 Starting a new non-formulary medication will require a non-formulary request form be completed.

2.6 Starting, stopping or continuing formulary medications on inmates will not affect the provisions of items 1.0 through 2.5 of this section.

2.7 The PRN II shall attach a copy of the means of verification to the prescription sent to the ADC pharmacy.

Arizona Department of Corrections	Procedures Managing Benzodiazepine Medications in Arriving Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 6.0	Supersedes: Procedural Instruction P0015 Effective Date: 8/15/11

Purpose: To provide direction regarding the processes under which an inmate's benzodiazepine medication may be continued/discontinued upon arriving in ADC custody.

Responsibility: It is the responsibility of the psychiatric provider to continue/discontinue benzodiazepine medications for inmates new to ADC custody in accordance with the protocols of this section.

1.0 When inmates are seen by a psychiatrist or psychiatric nurse practitioner (P/PNP):

1.1 The PRN II shall verify that the inmate is currently taking benzodiazepine medication through one of the following:

1.1.1 Receipt of a continuity of care form from the referring facility,

1.1.2 Documentation from a pharmacy, or

1.1.3 Current, properly labeled prescription bottles, or

1.1.4 Verification with outside medical records.

1.2 The P/PNP shall determine whether the inmate is taking the benzodiazepine medication for the treatment of a medical condition, a mental health condition or for the treatment of both a medical and a mental health condition.

1.3 For inmates taking benzodiazepine medications solely for the treatment of a medical condition, the inmate shall be referred to the general medical provider for orders.

1.4 For inmates taking benzodiazepine medications for the treatment of both a general medical condition and a mental health condition, the inmate shall be referred to the general medical provider to have the benzodiazepine managed.

1.5 For inmates taking benzodiazepines solely to treat a mental health condition, a titration/progressive discontinuation or taper of benzodiazepine shall be ordered by the P/PNP after the general medical provider clears the inmate medically. Patients whose daily dose is equal to or less than 2mg of Clonazepam, 2mg Lorazepam, 10mg diazepam, 1mg Alprazolam or the equivalent shall have the medication abruptly discontinued. Inmates on doses higher than those shall have their medication gradually tapered. Clonazepam shall be the sole benzodiazepine medication prescribed. A non-formulary request form shall not be required provided that the taper is scheduled to be complete within 21 days. Prescription duration in excess of 21 days will require a non-formulary request form.

1.6 The PRN II shall attach a copy of the means of verification of benzodiazepine use to the prescription sent to the ADC pharmacy.

1.7 A medical hold will be placed on inmates until the benzodiazepine taper is complete.

2.0 For inmates who for some reason are not seen by the P/PNP immediately upon arrival:

2.1 The PRN II shall verify that the inmate is currently taking benzodiazepine medication through one of the following:

2.1.1 Receipt of a continuity of care form from the referring facility,

2.1.2 Documentation from a pharmacy, or

2.1.3 Current, properly labeled prescription bottles, or

2.1.4 Verification with outside medical sources.

2.2 The PRN II shall attach a copy of the means of verification of benzodiazepine use to the prescription sent to the ADC pharmacy.

2.3 Benzodiazepine medication can be continued for up to 7 days without a non-formulary request.

2.4 Clonazepam shall be the sole benzodiazepine prescribed.

2.5 When inmates arrive at ADC on benzodiazepines other than Clonazepam, the following conversion formula will be used to calculate the equivalent dosage of Clonazepam which they will be prescribed:

BENZODIAZEPINE CONVERSION FORMULA:
CLONAZEPAM 1 mg per day =
ALPRAZOLAM 0.5 mg per day =
LORAZEPAM 2 mg per day =
DIAZEPAM 5 mg per day =
CHLORDIAZEPOXIDE 15 mg per day =
OXAZEPAM 15 mg per day

Arizona Department of Corrections	Management of Photosensitivity Reactions to Medications	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 7.0	Supersedes: Procedural Instruction P0016 Effective Date: 8/15/11

Purpose: To provide direction regarding the management of photosensitivity reactions resulting from an inmate's use of psychiatric medication.

Responsibility: It is the responsibility of the psychiatrist, psychiatric nurse practitioner (P/PNP), and/or PRN II to assess any photosensitivity reactions and duly act in accordance with the protocols outlined in this section.

1.0 All cases of inmate reported photosensitivity shall be verified by direct clinical examination by the medical staff. In all cases there shall be documentation of an unequivocal diagnosis of significant sunburn (to include erythema at a minimum), in the medical record or mental health progress notes.

2.0 If the P/PNP determines that the inmate's psychotropic medication is contributing to their photosensitivity, the P/PNP shall meet with the inmate and discuss treatment alternatives including medications having less marked photosensitizing effects.

3.0 For cases in which the P/PNP and inmate agree that switching psychotropic medications is not desirable, the inmate will be counseled as to proper use of sunscreen. The P/PNP will order sunscreen minimum SPF 30. The sunscreen order will be for 1 bottle per month with adequate refills to supply the inmate.

4.0 Inmates will not be issued special duty statuses, special clothing or hats.

Arizona Department of Corrections	Managing Medication Distribution Watch and Post Watch	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 8.0	Supersedes: Procedural Instruction P0018 Effective Date: 8/15/11

Purpose: To provide direction regarding the management of psychiatric and medical medications with regards to inmate's who have been discontinued from watch status.

Responsibility: The psychiatric provider, or other provider as indicated, will order the psychiatric and medical medications for an inmate removed from watch to be dispensed in accordance with the protocols of this section.

1.0 Inmates who are put on suicide or mental health watch shall have all their medications dispensed Watch/Swallow (W/S).

2.0 The Psychiatrist or PNP shall write a new prescription changing all the inmate's psychotropic medications to W/S status and document the change on a progress note in the mental health record.

3.0 The medical and/or psychiatric nurse will change all medication to watch swallow status upon the initiation of the watch.

4.0 After being taken off of a continuous, ten minute or thirty minute watch, inmates will continue to receive their medications Watch /Swallow until otherwise indicated by the psychiatrist or psychiatric ~~mental health~~ nurse practitioner.

5.0 The psychiatric provider shall, within 30 days after the release of the inmate from Watch status, determine if continued W/S administration is necessary. When the psychiatric provider decides to keep an inmate on W/S status, the general medical provider shall write "overdose risk per psychiatry" on succeeding prescriptions. An exception request will not be required.

6.0 Inmates who the psychiatrist or psychiatric nurse practitioner decide to keep on Watch/Swallow meds shall have their need for continued Watch/Swallow status assessed by the psychiatric provider at each following psychiatric appointment and will not be returned to Keep on Person [KOP] Medication status until indicated by the psychiatrist or psychiatric nurse practitioner.

7.0 When the psychiatric provider concludes that the inmate can safely self-administer KOP meds, the respective providers shall submit new prescriptions containing the change to the pharmacy and document the change in their individual progress notes.

7.1 The psychiatry provider will also document the change to keep on person [KOP] medication administration in the medical progress notes.

7.2 The record will be forwarded to the general medical provider for review.

Arizona Department of Corrections	Protocols for Referral of Inmates for Psychiatric Services	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 9.0	Supersedes: Procedural Instruction P0021 Effective Date: 8/15/11

Purpose: To provide a standardized protocol regarding referrals to psychiatric providers for medication treatment of mental health conditions.

Responsibility: It is the responsibility of the referring mental health/medical staff to operate in accordance with the protocols outlined in this section.

1.0 Mental Health staff may refer inmates to psychiatry for further evaluation and/or treatment whenever the clinical presentation would warrant a referral.

2.0 Mental Health staff shall not refer inmates to psychiatry when the primary complaint is inability to sleep that is not secondary to a mental health diagnosis.

Arizona Department of Corrections	Procedures for Voluntary, Involuntary, and Emergency Use of Psychiatric Medications	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 10.0	Supersedes: Procedural Instructions P0022A, P0022B Effective Date: 8/15/11

Purpose: To provide guidance to psychiatric providers [or other providers when necessary] in situations where voluntary, involuntary, and emergency dispensing of psychiatric medications to incarcerated individuals is clinically indicated as a means of treating a mental disorder or reducing an inmate's risk of serious self injury and/or the potential for injury to others as the result of a mental disorder.

Responsibility: The psychiatric prescriber is responsible for assessing, and if necessary, ordering the use of psychiatric medication in accordance with the protocols of this section.

1.0 Voluntary Use of Psychiatric Medications

1.1 When voluntarily administering psychotropic medication, the psychiatrist or psychiatric nurse practitioner shall:

1.1.1 Complete the appropriate Informed Consent for Psychotropic Medication Form (1103-12P).

1.1.1.1 In the event the inmate refuses to sign the form, the attending staff shall write "refused to sign" on the inmate signature line.

1.1.1.2 If an approved medication consent form specific for the proposed medication is available, it should be utilized in place of Form 1103-12P.

1.1.2 Document, on the Mental Health Progress Notes the reason for prescribing psychotropic medication, and the dosage and duration of the medication.

1.1.2.1 Prepare a prescription to dispense psychotropic medication.

1.1.2.2 Ensure, in conjunction with Pharmacy and Nursing staff, that the inmate receives the psychotropic medication within a medically appropriate time frame.

1.2 Psychiatrists and psychiatric nurse practitioners may prescribe psychotropic medication and administer it voluntarily to inmates who are inpatients at the Alhambra Behavioral Treatment Facility if, in their opinion, the medication is necessary for the treatment of a mental disorder.

1.3 When voluntarily or involuntarily administering psychotropic medication, the health care professionals responsible for administering the psychotropic medication and documenting compliance with the psychiatrist's or psychiatric nurse practitioner's prescription for psychotropic medication shall:

1.3.1 Only dispense psychotropic medication that has been ordered in a current prescription by a psychiatrist or psychiatric nurse practitioner and is labeled.

1.3.2 Copy each medication order onto the Medication Administration Record (MAR).

1.3.3 Complete a laboratory requisition, if indicated.

1.3.4 Bracket, after transcribing the orders, all orders in RED and write "noted," followed by the date, time, the health care professional's legal name and professional title.

1.3.5 Document, on the medication sheet, all psychotropic medication that is administered.

1.3.6 Inform the psychiatrist or psychiatric nurse practitioner of any adverse reactions to the psychotropic medication, and document the information in the mental health progress notes and on the medication sheet.

1.3.7 Keep all psychotropic medication in containers bearing the pharmacist's original label and store it in a securely locked medicine cabinet where the institution's prescription medications are stored and dispensed.

1.3.8 Administer psychotropic medication to inmates by one of the following methods, as determined by reviewing the prescription:

1.3.8.1 By unit dose.

1.3.8.2 By daily dose.

1.3.8.3 By watch swallow.

1.3.8.3.1 Any health care professional may place an inmate on watch swallow if he or she suspects that the inmate may not take the medication as prescribed.

1.3.8.3.2 Watch swallow can only be discontinued with written orders from the psychiatrist or psychiatric nurse practitioner.

1.3.8.4 By keep on person.

1.3.8.5 By intra-muscular injection.

2.0 Involuntary Emergency Use of Psychiatric Medications

2.1 A psychiatrist or psychiatric nurse practitioner [or another attending physician/physician assistant/or nurse practitioner if a psychiatrist or psychiatric nurse practitioner are unavailable] may order emergency psychotropic medication for and administer it involuntarily to an inmate with a mental disorder if, after evaluating the severity of the inmate's symptoms and the likely effects of the particular drug to be used, the psychiatrist or psychiatric nurse practitioner determines that:

2.1.1 An emergency exists in which the inmate's conduct presents a likelihood of imminent serious bodily harm to self or others.

2.1.2 Alternative methods of confinement or restraint are inadequate.

2.1.3 Forced medication is required, as a last resort, to address the emergency.

3.0 Involuntary Non-Emergency Use of Psychiatric Medications

3.1 In the absence of an emergency an inmate may be medicated involuntarily with psychotropic medication, for a maximum of six months, if the following conditions have been met:

3.1.1 The inmate suffers from a diagnosed mental disorder.

3.1.2 The treating psychiatrist or psychiatric nurse practitioner has determined that, due to a mental disorder, the inmate is either severely impaired or the inmate's conduct presents a likelihood of serious harm to self, others or property.

3.1.2.1 "Severely impaired" is defined as significant deterioration in cognitive functioning, reality testing, or volitional control over actions.

3.1.2.2 "Serious harm to self, others or property" is defined as action or lack of action resulting in bodily harm or risk to health, safety or damage to inmate or ADC property.

3.1.3 The psychiatrist or psychiatric nurse practitioner has concluded that there is a substantial likelihood that psychotropic medication will ameliorate the inmate's condition and has prescribed medication in the medical interest of the inmate as an integral part of the treatment plan.

3.1.4 The inmate has been offered and has refused the opportunity to voluntarily participate in the treatment plan, including the medication component.

3.1.5 A Psychotropic Medication Review Board (PMRB) has reviewed the matter according to the procedure below in 3.2 through 3.8.2 and determined that:

3.1.5.1 The inmate suffers from a mental disorder.

3.1.5.2 The inmate is severely impaired or his/her conduct presents a likelihood of serious harm to self, others or property.

3.1.5.3 The proposed medication is in the inmate's medical interest.

3.2 A mental health staff member shall give the inmate at least (24) twenty-four hours written notice (excluding weekends and holidays) of the psychiatric provider's intent to convene an involuntary medication hearing before a Psychotropic Medication Review Board, during which time the inmate may not be involuntarily medicated, [unless in an emergency situation] as defined in section 2.0 though 2.1.3 of this policy.

3.2.1 The notification is to be on the Notification of Intent to Request Approval for Involuntary Medication (Form 1103-15P) and shall include the treating psychiatric provider's tentative diagnosis of the inmate, the factual basis for the diagnosis, and a statement as to why the psychiatric provider believes medication is necessary and in the inmate's medical interest.

3.2.2 The Notification of Intent to Request Approval for Involuntary Medication (Form 1103-15P) shall be distributed as follows:

3.2.2.1 White copy: Legal/Administrative section, inmate medical record

3.2.2.2 Canary copy: Chief Psychologist

3.2.2.3 Pink copy: Inmate

3.3 The Chief Psychologist (or designee) shall schedule a meeting of the Psychotropic Medication Review Board (PMRB), to be held no earlier than 24 hours and no later

than 72 hours (excluding weekends and holidays) after the inmate's receipt of the "Notification of Intent to Request Approval for Involuntary Medication."

3.3.1 The PMRB shall be composed of one non-treating psychiatrist, one non-treating psychologist, and one Deputy Warden or Associate Deputy Warden.

3.3.2 The psychiatrist shall chair the PMRB hearing.

3.4 Notification of the PMRB hearing must include the date and time of the Review Board Meeting and shall:

3.4.1 Be provided to the inmate using the Psychotropic Medication Review Board Notification of Hearing and Inmate's Rights (Form 1103-1P).

3.4.2 Be communicated to the inmate's Correctional Officer III (COIII), the treating psychiatric provider, and the PMRB members of the hearing by the Chief Psychologist (or designee).

3.5 The "Psychotropic Medication Review Board Notification of Hearing and Inmate's Rights" form shall be distributed as follows:

3.5.1 White copy: Legal/Administrative section, inmate medical record

3.5.2 Green copy: Treating psychiatric provider

3.5.3 Canary copy: Deputy Warden or Associate Deputy Warden

3.5.4 Pink copy: Inmate's COIII

3.5.5 Goldenrod copy: Inmate

3.6 The inmate has the right to attend or refuse to attend the hearing:

3.6.1 If after encouragement the inmate refuses to attend the hearing it will be documented on the Finding of the Psychotropic Medication Review Board (Form 1103-2p).

3.6.2 At the discretion of the PMRB panel, present evidence and cross-examine witnesses.

3.7 If the committee determines, by a majority vote, that the inmate suffers from a mental disorder and is severely impaired or poses a likelihood of serious harm to self, others, or property, the inmate may be medicated against his/her will, provided the PMRB psychiatrist is in the majority.

3.7.1 The inmate will be informed of the PMRB results within 8 hours via receipt of the Finding of the Psychotropic Medication Review Board (Form 1103-2P).

3.8 The inmate may appeal the Board's decision to the Division Director for Health Services, or his/her designee, by notification via an inmate letter, within 24 hours (excluding weekends and holidays) of receipt of the PMRB's decision.

3.8.1 The inmate letter will be electronically sent to the Division Director for Health Services, along with copies of relevant psychiatrist or psychiatric nurse practitioner documentation and the Findings of Psychotropic Medication Review Board form.

3.8.2 The Division Director for Health Services, or his/her designee, shall decide the appeal and notify the inmate through the Chief Psychologist or designee of the decision, via electronic transmission, within 24 hours of receipt (excluding weekends and holidays).

3.8.3 Within four hours of receipt of the Division Director's decision the Chief Psychologist or designee shall provide copies of the decision to the

inmate, the inmate's Correctional Officer III, the treating Psychiatrist, and the PMRB chair.

3.8.4 During the appeal period, in the absence of an emergency as defined in this Section, the inmate shall not be involuntarily medicated.

3.8.5 In the event that the appeal is upheld, the inmate shall not be involuntarily medicated unless in the presence of an emergency as defined in this Section or by a Court order.

3.9 The treating psychiatrist may request a new involuntary medication hearing no sooner than fourteen working days after the appeal is upheld.

3.9.1 If the PMRB approves the involuntary administration of psychotropic medication of an inmate, and there is no upheld appeal, the PMRB shall review the inmate's case within three months and approve or disapprove, by use of the criteria cited in this Order, the continuance of involuntary medication for an additional three months.

3.9.1.1 The PMRB's decision is final and not subject to appeal.

3.9.2 If involuntary medication is re-approved, the PMRB shall again review and approve or disapprove, by the criteria cited herein, the continuance of involuntary medication for an additional three months.

3.9.3 At any time that the inmate becomes compliant with his medication and agrees to voluntarily take them, the treating psychiatrist shall so note in the inmate's medical record, though the PMRB order shall remain in effect unless rescinded by the PMRB or it expires.

3.9.4 Whenever the PMRB meets to review an inmate's case, the FHA or designee shall provide the PMRB with a copy of all mental health records, laboratory results received, and any HNRs received from the inmate, since the last PMRB hearing.

3.9.5 At the end of the six month involuntary medication period, the PMRB order for involuntary medication shall expire.

3.9.6 The treating psychiatrist may, pursuant to the criteria above, again seek authorization to involuntarily medicate the inmate with psychotropic medication.

3.10 Nothing in this order shall relieve the treating psychiatrist from responsibility for adhering to Department written instructions.

3.11 Psychiatrists may also prescribe psychotropic medication and administer it involuntarily to inmates who are involuntarily-committed patients at the Alhambra Behavioral Treatment Facility if **one** of the following apply:

3.11.1 The conditions in 1103.08, 1.4 through 1.4.3 exist.

3.11.2 In a non-emergency, a review and consent is obtained from a committee composed of staff physicians and psychiatrists/licensed psychologists.

Arizona Department of Corrections	Protocols for Psychiatric Services at Non-Corridor Complexes	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 11.0	Supersedes: MHTM 4.0 Effective Date: 8/15/11

Purpose: To provide guidance regarding the processes for provision of psychiatric services to inmates housed at non-corridor complexes.

Responsibility: The mental health provider at a non-corridor facility, or other health services provider as necessary, is responsible for initiating/coordinating the psychiatric services/referral/ transfer of the mentally disordered inmate to their assigned corridor facility in accordance with the protocols of this section.

1.0 Each non-corridor facility will have a corridor facility with which they are affiliated for purposes of psychiatric coverage.

2.0 Procedure

- 2.1 An inmate identified by Mental Health staff as needing a psychiatric evaluation or psychiatric care shall be scheduled for the next psychiatric provider or psychiatric nurse practitioner appointment line.
- 2.2 A Psychiatric Registered Nurse II or mental health designee will advise the assigned psychiatric provider or psychiatric nurse practitioner, and arrange a conference call to triage and discuss the inmate's status and reason for referral.
- 2.3 Inmates identified as needing to be seen by the psychiatric provider or psychiatric nurse practitioner will be transported to the appropriate facility by security staff from the sending unit. Telemedicine appointments may be scheduled where appropriate, following Telemedicine Technical Manual procedures.
- 2.4 Each corridor facility providing psychiatric services to a non-corridor facility will establish, in conjunction with the Facility Warden and Deputy Warden, a regularly scheduled day and time for these services.
- 2.5 The inmate's medical record shall accompany the inmate to the corridor facility appointment.
- 2.6 Inmates placed on medication will be returned to the sending facility. The next work day a designated Mental Health clinician will initiate appropriate paperwork to the Health Services Division Director, in Central Office, to expedite the inmate's transfer to a corridor complex.
- 2.7 The affiliated corridor complex will provide emergency support services to the designated non- corridor complex.

2.8 Inmates requiring Alhambra Behavioral Health Treatment Facility (ABHTF) evaluations will be triaged by phone with the designated corridor complex Chief Psychologist first. If the Chief Psychologist agrees that an inpatient evaluation is needed, he/she will contact the ABHTF Clinical Director to arrange for the admission.

2.9 Inmates arriving at a non-corridor facility on psychotropic medication will be triaged with the designated psychiatric provider via telephone conference call within two (2) working days of inmate's arrival and a decision made regarding need for transfer.

2.10 Affiliations for outlying facilities will be designated by the Division Director of Health Services in consultation with the MHPM, or designee.

Arizona Department of Corrections	Inmate Follow-up After Discontinuation Of Psychiatric Medication	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 12.0	Supersedes: None - New Effective Date: 8/15/11

Purpose: To provide direction regarding the protocols and personnel involved in the timely initiation and assessment of inmates who have been discontinued from, or refused their, psychiatric medications.

Responsibility: It is the responsibility of the psychiatric providers on complex to indicate in the inmate's medical chart the need for an assessment following the complete discontinuation of psychiatric medication, due to either planned discontinuance or inmate refusal.

1.0 Following the planned discontinuation of psychiatric medication an inmate will receive a follow-up assessment to determine whether further need for medication services exists.
- 1.1 Follow-up assessment will be provided:
  - 1.1.1 By a PRN II or other qualified mental health/health services staff member
  - 1.1.2 No less than 30 days but no more than 60 days from the last day of prescribed medication(s)

2.0 Following any unplanned complete discontinuation of psychiatric medication an inmate will receive a follow-up assessment to determine whether the inmate's current mental health presentation, symptom severity [if any], and potential for benefit from psychiatric medications warrant additional action from mental health/health services staff.
- 2.1.1 Follow-up assessments will be provided:
  - 2.1.1.1 By a PRN II or other qualified mental health/health services staff member.
  - 2.1.1.2 Initially within (7) seven days, with an additional follow-up scheduled for no less than 30 days but no more than 60 days from the last day medication(s) were taken.

Arizona Department of Corrections	Antipsychotic Medication Protocol	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 13.0	Supersedes: Procedural Instruction P0005 Effective Date: 8/15/11

Purpose: To provide direction regarding the use of antipsychotic medications by authorized medical personnel.

Responsibility: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 All inmates who are prescribed antipsychotic medications shall have adequate assessment and monitoring done to ensure that treatment is necessary and effective, in the inmate's best interest, and the possibility of toxic side effects is minimized.

2.0 Antipsychotic medications shall be prescribed by psychiatrists or mental health nurse practitioners who take all customary actions to establish that treatment is necessary including taking an adequate psychiatric history and performing an adequate mental status examination, pre-treatment evaluation of involuntary movements (Abnormal Involuntary Movement Scale (AIMS).

3.0 Psychological testing in consultation with psychology and review of prior ADC and non-ADC medical records and institutional records will occur when necessary to establish the inmate's mental health diagnoses with reasonable certainty.

4.0 Inquiries as to an inmate's functional status with non-medical correctional staff (such as housing unit, educational, recreation and administrative staff) will occur when necessary to establish an inmate's functional status with reasonable certainty.

5.0 The prescribing provider shall select the specific antipsychotic medication and determine the dose to be used by considering the individual inmate's diagnosis and history and in compliance with the ADC formulary.

6.0 To be considered a failed trial, all antipsychotic medication trials shall be of at least four weeks duration at the target dosage unless (defined in item 9), unless limited by unmanageable adverse effects. Trials occurring prior to the inmate's arrival at ADC must be confirmed by outside medical records. Trials which occurred during periods of active alcohol or illicit drug abuse shall not be considered adequate

7.0 In some cases (especially involving inmate reports of previous life-threatening adverse reactions) temporary non-formulary approval may be granted for up to 90 days while outside records are obtained. It is the responsibility of the prescribing provider, through an order given to the psychiatric nurse, to notify the Medical Records Department that prior records are needed.

8.0 Lower doses than those in item 9 below shall be used for inmates who respond well to lower doses or who develop unmanageable adverse effects at higher doses.

9.0 Target doses for non-responders without limiting side effects are as follows:

9.1 For conventional antipsychotics:

9.1.1 Haloperidol 15mg per day
9.1.2 Fluphenazine 15mg per day
9.1.3 Trifluoperazine 30mg per day
9.1.4 Perphenazine 32mg per day
9.1.5 Chlorpromazine 750mg per day
9.1.6 Thiothixine 30mg per day

9.2 For atypical antipsychotics:

9.2.1 Risperidone 6mg per day
9.2.2 Invega 6mg per day
9.2.3 Ziprasidone 160mg per day
9.2.4 Abilify 15mg per day

10.0 For inmates with neither significant tardive dyskinesia (Abnormal Involuntary Movement Scale score greater than five) nor a history of Neuroleptic Malignant Syndrome, the initial medication shall be a conventional antipsychotic or risperidone.

11.0 If risperidone and one or more conventional antipsychotics are all either ineffective or not tolerated, then Geodon, Invega or Abilify shall be used. The maximum dose of Abilify shall be 15mg per day; Risperidone 6mg per day; Invega 6mg per day; Ziprasidone 160mg per day; higher doses require a non-formulary request.

12.0 Non-formulary medications shall be requested only after a conventional antipsychotic, risperidone, ziprasidone and Abilify have all been tried.

13.0 Prescribing providers shall take all reasonable precautions to minimize the occurrence of side effects including:

13.1 Use of the lowest necessary dose.

13.2 Order body weight, fasting blood sugar and serum lipid levels at the time of initiating antipsychotic medication and repeat assessments of body weight, fasting blood sugar and serum lipid levels after three, six and twelve months of treatment and every year thereafter

13.3 Repeat administration of scales to measure involuntary movements (AIMS) every six months.

14.0 All conventional antipsychotics (prescribed within FDA dosage guidelines) may be prescribed without a Non-Formulary request being required.

Arizona Department of Corrections	Mood Stabilizer Medication Protocol	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 14.0	Supersedes: Procedural Instruction P0012 Effective Date: 8/15/11

Purpose: To provide direction regarding the use of mood stabilizer medications by authorized medical personnel.

Responsibility: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 Serum drug levels should be drawn 10-14 hours after the ingestion of medication.

2.0 The prescribing Psychiatrist or Psychiatric Nurse Practitioner (P/PNP) shall order serum drug levels to be done one to two weeks after starting treatment and one to two weeks after every dose increase.

3.0 When doses are stable, serum drug levels should be repeated after three and six months of treatment, and then every six months thereafter. Serum drug levels may be ordered more frequently when clinically indicated.

4.0 When ordering lithium levels, the P/PNP shall also order an automated chemistry profile (ACP).

5.0 When ordering Depakote and Carbamazepine levels, the P/PNP shall also order an ACP and complete blood count with differential (CBC).

6.0 For inmates starting lithium, the P/PNP shall order a baseline EKG if the inmate has pre-existing cardiac disease or is age 45 or older.

7.0 The psychiatric nurse shall have a standing order for serum liver function testing (Automated Chemistry Panel or the equivalent) on arriving inmates who are taking Depakote or carbamazepine at PV Reception, ARTC (or as parole violators at other complexes).

8.0 Eskalith CR and Lithobid may be used without a non-formulary request in inmates who do not tolerate regular release lithium.

9.0 Inmates prescribed Lithium shall have baseline and annual monitoring of their TSH (thyroid stimulating hormone).

Arizona Department of Corrections	Lamitcal (Lamotrigine) Medication Protocol	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 15.0	Supersedes: Procedural Instruction P0013 Effective Date: 8/15/11

Purpose: To provide direction regarding the use of the medication Lamitcal (Lamotrigine) by authorized medical personnel.

Responsibility: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 Lamotrigine will be prescribed to inmates whose Bipolar depressive symptoms are severe or which resulted in suicide attempts or hospitalization.

2.0 Lamotrigine will be prescribed to inmates with Bipolar depression who have intolerable adverse effects or fail to respond to Lithium, Carbamazepine, Depakote and Antidepressants.

3.0 Inmates should be started on 25mg at night. There should be no dose increase for the first two weeks. Thereafter, the dose should be increased no more rapidly than by an additional 25mg per day every two weeks.

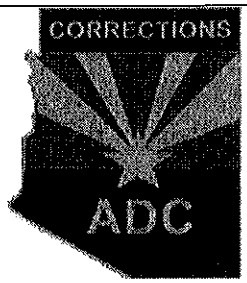
4.0 The maximum dose should not exceed 250mg each day.

5.0 Lamotrigine should be immediately discontinued if the patient develops a drug- related rash.

6.0 Patients with a history of rash due to Lamotrigine should not be prescribed Lamotrigine.

7.0 Inmates prescribed Lamotrigine will be put on a medical hold which keeps them at their current unit. The psychiatrist or mental health nurse practitioner ordering Lamotrigine shall notify the Chief Psychologist to enter a Medical Hold on the AIMS DT08 97 screen. The medical hold may be temporarily lifted to allow movement once arrangements have been made to ensure uninterrupted administration of medication at a receiving unit. The Chief Psychologist will then enter a new Medical Hold keeping the inmate at the receiving unit.

8.0 Lamotrigine will only be used at ASPC-PHX, ASPC-Tucson, ASPC-Lewis, ASPC-Eyman and ASPC-Perryville.

 Arizona Department of Corrections	Managing Psychostimulant Medications in Arriving Inmates	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 16.0	Supersedes: Procedural Instruction P0017 Effective Date: 8/15/11

Purpose: To provide authorized medical personnel direction regarding the management of psychostimulant medication in arriving inmates.

Responsibility: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 Inmates arriving on psychostimulant medications shall be seen as soon as possible by the Psychiatrist or Psychiatric Nurse Practitioner (P/PNP).

1.1 When inmates are seen by the P/PNP:

1.1.1 The P/PNP shall determine whether the inmate is taking the stimulant medication for the treatment of a medical condition, a mental health condition or for the treatment of both a medical and a mental health condition.

1.1.2 For inmates taking stimulant medications solely for the treatment of a medical condition, the inmate shall be referred to the general medical provider for orders.

1.1.3 For inmates taking stimulant medications for the treatment of both a general medical condition AND a mental health condition, the inmate shall be referred to the general medical provider to have the stimulant medication managed.

1.1.4 For inmates taking stimulants solely to treat a mental health condition, discontinuation of medication shall be ordered by the P/PNP.

1.2 When inmates for some reason cannot be seen by the P/PNP immediately upon arrival:

1.2.1 The Psychiatric Nurse II shall attach either a copy of the continuity of care form or a copy of the SOAP note documenting verification from the referring facility to the prescription sent to the ADC pharmacy.

1.2.2 Nortriptyline will become the first line for ADHD. At a dose of 25-75 mg per day. Blood levels would be required for doses greater than 75mg.

Arizona Department of Corrections	Antidepressant Medication Protocol	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 17.0	Supersedes: Procedural Instruction P0020 Effective Date: 8/15/11

Purpose: To provide direction regarding the use of antidepressant medications by authorized medical personnel.

Responsibility: It is the responsibility of all authorized medical personnel to act in accordance with this policy.

1.0 All inmates who are prescribed antidepressant medications shall have adequate assessment and monitoring to ensure that treatment is necessary and effective, in the inmate's best interest, and the possibility of toxic side effects is minimized.

2.0 Antidepressant medications shall be prescribed by psychiatrists or psychiatric nurse practitioners who take all customary actions to establish that treatment is necessary including taking an adequate psychiatric history and performing an adequate mental status examination.

3.0 Psychological testing in consultation with psychology and review of prior ADC and non-ADC medical records and institutional records will occur when necessary to establish the inmate's mental health diagnoses with reasonable certainty.

4.0 Inquiries as to an inmate's functional status with non-medical correctional staff (such as housing unit, educational, recreation and administrative staff) will occur when necessary to establish an inmate's functional status with reasonable certainty.

5.0 The prescribing provider shall select the specific antidepressant medication and determine the dose to be used by considering the individual inmate's diagnosis and history and in compliance with the ADC formulary.

6.0 To be considered a failed trial, all antidepressant medication trials shall be of at least six weeks duration at the target dosage unless limited by unmanageable adverse effects. Trials occurring prior to the inmate's arrival at ADC must be confirmed by outside medical records. Trials which occurred during periods of active alcohol or illicit drug abuse shall not be considered adequate.

6.1 In some cases (especially involving inmate reports of previous serious adverse reactions) temporary non-formulary approval may be granted for up to 90 days while outside records are obtained. It is the responsibility of the prescribing provider, through an order given to the psychiatric nurse, to notify the Medical Records Department that prior records are needed.

7.0 Lower doses than those in item 8 below shall be used for inmates who respond well to lower doses or who develop adverse effects at higher doses.

8.0 Target doses for non-responders without limiting side effects are as follows:
- 8.1 Fluoxetine 20mg per day (tier 1)
- 8.2 Citalopram 40mg per day (tier 1)
- 8.3 Sertraline 100mg per day (tier 1)
- 8.4 Paroxetine 40mg per day (tier 2)
- 8.5 Nortriptyline augmentation 50-75mg per day (tier 2)
- 8.6 Venlafaxine XR 150mg per day (tier 3)

9.0 For inmates without a history of prior, serious adverse reactions the initial antidepressant medication shall be fluoxetine, citalopram or sertraline.

10.0 If the initial agent tried was ineffective or not tolerated, an alternate medication in item 9 shall be used.

11.0 If two first tier medications (from item 10) are either ineffective or not tolerated, then paroxetine or nortriptyline (second tier) may be used. A non-formulary request will not be required. Providers may use medications in tier 2 (paroxetine or nortriptyline) without first trying those in item 9 if the inmate has a past history of a positive response to the tier two medication. A non-formulary request will not be required. Nortriptyline may be used alone or in combination with an SSRI.

12.0 If three SSRI's are ineffective or not tolerated, then venlafaxine XR may be used. The maximum dose of venlafaxine XR will be 150mg per day. Higher doses shall require a non-formulary request.

13.0 Non-formulary medications shall be requested only after three SSRI's and venlafaxine XR have been tried.

14.0 Prescribing providers shall take reasonable precautions to monitor for the occurrence of adverse effects. Inmates with a history of heart disease or older than 45 years of age shall have an EKG prior to commencing nortriptyline. Inmates taking more than 75mg nortriptyline per day shall have a serum nortriptyline level checked to insure that it is not within the toxic range (above 200ng/ml). Serum nortriptyline levels will be drawn 10-14 hours after the ingestion of medication and after the inmate has been taking the same dosage for at least five days. Inmates taking more than 50mg per day of nortriptyline concurrently with medications which could elevate nortriptyline levels (i.e. fluoxetine, paroxetine) shall have a serum nortriptyline level checked to insure that it is not within the toxic range (above 200ng/ml). Nortriptyline will always be dispensed watch / swallow.
- 14.1 Inmates taking more than 75mg per day of any tricyclic antidepressant shall have a serum level checked to insure that it is not within the toxic range. Inmates taking more than 50mg per day of any tricyclic antidepressant will have a serum level checked if they are concurrently prescribed fluoxetine, paroxetine or any other medication which could inhibit tricyclic antidepressant metabolism.
- 14.2 The maximum dose of nortriptyline for use in ADHD will be 75mg per day. Higher doses shall require a non-formulary request accompanied by a serum nortriptyline level result drawn while the inmate was taking 75mg per day.
- 14.3 When inmates arrive at any complex directly from ARTC and ASPC-PV Reception areas, or directly as parole violators:

14.3.1 The PRN's have a standing order for a tricyclic antidepressant serum level on all inmates who arrive on greater than 75mg (76mg and above) of any tricyclic antidepressant.

Arizona Department of Corrections	Thorazine (Chlorpromazine) Medication Protocol	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 18.0	Supersedes: Procedural Instruction P0023 Effective Date: 8/15/11

Purpose: To provide direction regarding the use of the medication Thorazine (Chlorpromazine) by authorized medical personnel.

Responsibility: It is the responsibility of all authorized mental health medical providers to act in accordance with this policy.

1.0 Mentally disordered inmates who have been psychiatrically stabilized with chlorpromazine while at ABHTF shall have those treatments continued upon transfer to other corridor complex units for three (3) months to minimize risk of relapse upon transfer back to general population.

2.0 After three (3) months, a non-formulary medication request shall be required for mentally disordered inmates who have been psychiatrically stabilized with chlorpromazine while at ABHTF and then transferred back to general population units.

3.0 The treating psychiatrist/psychiatric nurse practitioner shall note the reason for continuation of chlorpromazine on the prescription (e.g., date of return from ABHTF).

4.0 Chlorpromazine will be non-formulary at all settings other than ABHTF.

Arizona Department of Corrections	Management of Heat Intolerance Reactions to Medications	OPR: Health Services Division Director
Mental Health Technical Manual	MHTM Chapter 5 Section 19.0	Supersedes: Effective Date: 8/15/11

Purpose: To provide direction regarding the management of Heat Intolerance reactions resulting from an inmate's use of psychiatric medication.

Responsibility: It is the responsibility of the psychiatrist, psychiatric nurse practitioner and/or PN II to assess any Heat Intolerance reactions and duly act in accordance with the protocols outlined in this section.

1.0 All cases of inmate reported Heat Intolerance shall be verified by direct clinical examination by the medical staff.

2.0 In all cases medical staff will document the direct clinical examination and the unequivocal diagnosis of hyperthermia (body temperature above 99.5 degrees) or orthostatic hypotension (drop of 20mm Hg or greater on rising), in a medical record note or mental health progress note.

3.0 If the inmate is currently prescribed medication by the psychiatrist/psychiatric nurse practitioner, medical staff will refer the inmate for evaluation by the psychiatrist/psychiatric nurse practitioner.

4.0 If the psychiatrist/psychiatric nurse practitioner determines that the inmate's psychotropic medication is contributing to their Heat Intolerance, the psychiatrist/psychiatric nurse practitioner shall meet with the inmate and discuss treatment alternatives including medications having less marked effects on heat tolerance.

5.0 For cases in which the psychiatrist/psychiatric nurse practitioner and inmate agree that switching psychotropic medications is not in the inmate's best interest, the psychiatrist/ psychiatric nurse practitioner shall consult with the medical provider regarding a duty status to minimize heat exposure.

Subject: **Psychiatry**
Number: **P0001**
Effective Date: 9/22/05
Last Revision: **8/31/11**
Title: **Citalopram**
Page 1 of 1

Based on the consensus of ADC psychiatric staff meeting on August 15 and September 8, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. All inmates currently receiving escitalopram (Lexapro) will be prescribed generic citalopram at their next psychiatric contact.

2. Maximum daily dose of Citalopram will not exceed 40mg.

Subject: **Psychiatry**
Number: **P0002**
Effective Date: 12/08/09
Title: **Mandatory Watch Swallow Medications**
Page 1 of 1

Based on the consensus of the the P&T meeting of 12/8/09 the following is instructed: ADC psychiatric staff meeting on August 15 and September 8, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. Provide most Mandatory W/S Psychotropics as Keep on Person except tricyclies, Chlorpromazine (Non-formulary for all sites except Baker/Flamenco), Lithium, Geodon, and Abilify or Non-Formulary Psych medications. Non-formulary medication EXCEPTIONS are Perphenzaine and Trifluoperazine which may be written as KOP rather than Watch Swallow. Keep on Person medication will be dispensed in a 28 day supply as ordered by the practitioner. Practitioner may continue to order all Mental Health medications WS if clinically indicated.

Subject: **Psychiatry**
Number: **P0003**
Effective Date: **9/22/05**
Last Revision: **4/10/07**
Title: **Continuation Of Polypharmacy Treatments For Inmates Stabilized At Alhambra Behavioral Health Treatment Facility (ABHTF)**

Based on the consensus of ADC psychiatric staff meeting on August 15 and September 8, 2005, and the Pharmacy and Therapeutics Committee meeting on September 22, 2005, the following is instructed:

1. Mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments (i.e., simultaneous typical and atypical antipsychotic medications) while at ABHTF shall have those treatments continued upon return to SMTU if necessary and as long as clinically indicated.

2. The treating psychiatrist/mental health nurse practitioner shall note the inmate's SMTU placement on the prescription.

3. Mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments (i.e., simultaneous typical and atypical antipsychotic medications) while at ABHTF shall have those treatments continued upon transfer to other corridor complex units for three (3) months to minimize risk of relapse upon transfer back to general population.

4. After three (3) months, a nonformulary medication request shall be required for mentally disordered inmates who have been psychiatrically stabilized with polypharmacy treatments while at ABHTF and then transferred back to general population units.

5. The treating psychiatrist/mental health nurse practitioner shall note the reason for continuation of polypharmacy treatment on the prescription (e.g., date of return from ABHTF).

Subject: **Psychiatry**
Number: **P0006**
Effective Date: **11/29/05**
Last Revision: **4/10/07**
Title: **Seroquel (Quetiapine) And Wellbutrin (Bupropion)**
Page 1 of 1

Consistent with the psychiatric literature and the experience of the ADC psychiatrists, it is found that Seroquel and Wellbutrin are sought and used as drugs of abuse in the correctional setting. This makes their use in the correctional setting hazardous for the inmates to whom they are prescribed as well as to the inmate population as a whole.

Therefore, following the consensus of the ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005, the following is instructed:

1. All inmates, excluding those currently at the Alhambra and Perryville Reception Centers, currently prescribed Seroquel or Wellbutrin will be prescribed alternative therapy at the time of their next evaluation by a psychiatrist/mental health nurse practitioner. Both medications will be discontinued within six weeks of that evaluation and alternative therapy, as clinically indicated, will be prescribed.

2. All inmates who arrive at the Alhambra and Perryville Reception Centers taking Seroquel or Wellbutrin may continue on those medications during the time in reception, if clinically indicated, until transfer to a complex where the inmate is to be permanently housed.

   A. Inmates arriving on Wellbutrin IR and XL will be switched to Wellbutrin SR.

3. All inmates arriving at an Arizona State Prison Complex, from the Alhambra and Perryville Reception Centers or as Parole Violators, who are taking Seroquel or Wellbutrin will be prescribed alternative therapy at the time of their next evaluation by a psychiatrist/mental health nurse practitioner. Both medications will be discontinued within six weeks of that evaluation. Alternative therapy, if clinically indicated, will be prescribed.

4. Inmates currently taking Seroquel or Wellbutrin, and with less than three months before their anticipated release from ADC, may continue on Seroquel and Wellbutrin, if clinically indicated.

Subject: ***Psychiatry***
Number : **P0007**
Effective Date: 11/29/05
Revision Date: **4/10/07**
Title: **Clozaril (Clozapine)**
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Based on the consensus of ADC Psychiatric Staff and the Pharmacy and Therapeutics Committee meeting on November 29, 2005 the following is instructed:

The Medical Program Manager and Mental Health Program Manager shall ensure that all staff comply with these procedures.

Clozapine is an atypical antipsychotic agent with efficacy in the management of individuals with schizophrenia or schizoaffective disorder. Clozapine is also utilized for those individuals who have intolerable adverse events with other conventional and atypical antipsychotics. The use of this agent carries a risk of agranulocytosis and has specific monitoring requirements dictated by the Food and Drug Administration (FDA). The guidelines for the use of this medication are as follows:

1. All patients treated with Clozapine will be housed at the Alhambra Behavioral Health Treatment Facility (ABHTF).

2. All patients will be educated regarding the potential adverse effects associated with Clozapine, as well as alternative treatments and informed consent will be obtained.

3. All prescribing physicians and patients will be registered with the Mylan Prescription Access System.

4. The ABHTF Health Services Pharmacy will dispense all of the Clozapine through the Mylan Prescription Access System.

5. Monday through Friday, excluding holidays, the pharmacy will print a list of patients with active orders for Clozapine and will send the list to the Clozapine prescribing psychiatrists and ABHTF medical providers.

6. The plan as set forth in Attachment A will be followed to monitor all complete blood count with differentials (CBC) and absolute neutrophil counts (ANC).

Subject: ***Psychiatry***
Number : **P0007**
Effective Date: 11/29/05
Revision Date: **4/10/07**
Title: **Clozaril (Clozapine)**
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7. The prescribing psychiatrist shall write the initial Clozapine titration schedule as a 14 or 16 day, or 3, 4, 5 or 6 week schedule.

8. Before dispensing the first dose, the Pharmacy will have received a rechallenge number. This will be done for all individuals who are receiving Clozapine (including both those receiving it for the first time and for those who have received Clozapine in the past).

9. Prior to dispensing the initial dose of Clozapine and all subsequent dispensing of Clozapine, the pharmacy and prescribing psychiatrist will verify that a baseline CBC and ANC were obtained by Lab Corp within 48 hours of the initial dose of Clozapine, and within 7 days for those patients being maintained on a weekly Clozapine monitoring schedule.

10. Clozapine will be dispensed for 7 days from the date of the most recent CBC and ANC if on weekly blood count monitoring, or 14 days if on biweekly monitoring, or 28 days if on monthly monitoring status.

11. If a CBC and ANC are NOT reported within 48 hours of the initiation of Clozapine therapy or within 7 days of weekly monitoring or 14 days of biweekly monitoring or 28 days of monthly monitoring, pharmacy will notify the Clozapine prescribing psychiatrist and psychiatric nurse coordinator and <u>WILL</u> <u>NOT</u> dispense any further Clozapine. The physician must reorder the CBC and ANC before further Clozapine dispensing will occur.

12. The laboratory, upon completion of a CBC and ANC will fax one copy of the blood results to the prescribing psychiatrist and one copy to the ABHTF pharmacy.

13. After review of the CBC and ANC, the Clozapine prescribing physician will either approve or disapprove the dispensing of Clozapine.

14. The pharmacy will complete and fax the CBC and ANC results per reporting Form C to the Mylan Clozapine Prescription Access System.

Subject: ***Psychiatry***
Number : **P0007**
Effective Date: 11/29/05
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Title: **Clozaril (Clozapine)**
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15. Pharmacy and the prescribing psychiatrist will screen all patient medication profiles for possible Clozapine drug interactions upon the initiation of Clozapine and upon the initiation of any other medication for patients taking Clozapine.
16. Carbamazepine will not be dispensed concurrently with Clozapine.
17. The Medical Program Manager, Mental Health Program Manager and the ABHTF Pharmacy Director will review the outcomes of the Clozapine monitoring programs on an annual basis and the procedural instruction will be reviewed and signed annually by all parties.

INITIATION OF THERAPY: HEMATOLOGICAL VALUES

1. Do not initiate in patients with a history of myeloproliferative disorder or Clozapine-Induced agranulocytosis or granulocytopenia.
2. The frequency of CBC and ANC monitoring is weekly for 6 months. After 6 months of continuous weekly therapy when all CBC results include a WBC greater than 3500/cc and ANC greater than 2000/cc, the prescribing physician can begin monitoring the CBC and ANC every 2 weeks for the following 6 months. After 12 months of continuous Clozapine therapy and all results for WBC are greater than 3500/cc and ANC greater than 2000/cc, the prescribing physician can then begin monitoring the CBC and ANC every 4 weeks.
3. If immature WBC forms are present on the CBC then the WBC and ANC should be repeated.
4. At discontinuation of Clozapine therapy, CBC and ANC's must be drawn weekly for at least 4 weeks from the day of discontinuation.
5. A substantial drop in WBC or ANC is defined by a single drop or cumulative drop within 3 weeks of WBC greater than 3000/cc or drop in ANC greater than 1500/cc . If this occurs a repeat WBC and ANC should be obtained. If repeated results are WBC between 3000/cc and 3500/cc and ANC greater than 2000/cc, then monitoring should occur twice weekly thereafter. When the WBC is greater than 3500/cc and the ANC is greater than 2000/cc return to previous monitoring frequency.

Subject: ***Psychiatry***
Number : **P0007**
Effective Date: 11/29/05
Revision Date: **4/10/07**
Title: **Clozaril (Clozapine)**
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6. Moderate leukopenia is defined as a WBC between 2000/cc and 3000/cc or ANC between 1000/cc and 1500/cc. If moderate leukopenia occurs then Clozapine therapy should be interrupted. Daily CBC and ANC should be obtained until the WBC is greater than 3000/cc and the ANC is greater than 1500/cc. Twice weekly CBC and ANC should be obtained until the WBC is greater than 3500/cc and ANC is greater than 2000/cc. The prescribing psychiatrist may rechallenge (restart Clozapine) when the WBC is greater than 3500/cc and the ANC is greater than 2000/cc. If rechallenged, monitor the CBC and ANC weekly for 1 year before returning to the usual monitoring schedule of every 2 weeks for 6 months, then every 4 weeks thereafter.

7. Severe leukopenia is defined as a WBC less than 2000/cc and severe granulocytopenia as when ANC is less than 1000/cc. If either of these occur discontinue Clozapine treatment and do not rechallenge patient (do not restart Clozapine). Monitor WBC and ANC until normal for at least 4 weeks from the date of discontinuation as follows:

    Daily CBC and ANC until the WBC is greater than 3000/cc and the ANC is greater than 1500/cc, then twice weekly until the WBC is greater than 3500/cc and the ANC is greater than 2000/cc then weekly for 4 weeks after the WBC is greater than 3500/cc and the ANC is greater than 2000/cc.

8. Agranulocytosis is defined as ANC less than 500/cc. If this occurs discontinue treatment and do not rechallenge patient (do not restart Clozapine). Monitor CBC and ANC until normal for at least 4 weeks from day of discontinuation as per item 7 above.

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9. If Clozapine therapy is interrupted for reasons other than abnormal hematological results, then see Attachment B for what monitoring frequency to resume after interruption of Clozapine therapy.

CLOZARIL: Starting a Patient

1. Call the CLOZARIL National Registry (CNR) to obtain a rechallenge number and to confirm that you and your pharmacy are registered.
2. Obtain a baseline WBC with ANC from patient. If within normal limits, WBC ≥ 3500/mm³, ANC ≥ 2000/mm³, prescribe CLOZARIL tablets.
3. Submit WBC and ANC information to the registered pharmacy.
4. Please be prepared to provide your DEA # to the CNR when you are registered for the first time.

For forms, patient enrollment, or medical information call the CLOZARIL National Registry:

1-800-448-5938

Recommended CLOZARIL® (clozapine) dosage titration at start of therapy[1]

Week 1	am (mg)	hs (mg)	Total (mg)	Week 2	am (mg)	hs (mg)	Total (mg)
Day 1	12.5	12.5*	12.5-25	Day 8	50	100	150
Day 2	25	–	25	Day 9	100	100	200
Day 3	25	25	50	Day 10	100	100	200
Day 4	25	50	75	Day 11	50	200	250
Day 5	50	50	100	Day 12	50	200	250
Day 6	50	75	125	Day 13	100	200	300
Day 7	50	100	150	Day 14	100	200	300

*Optional Subsequent dosage increments should be made no more than once or twice weekly, in increments not to exceed 100 mg.

CLOZARIL: Managing the Patient

Current Monitoring Frequency	Eligibility for Monthly Monitoring
Every 2 weeks (biweekly) for 6 continuous months, following 6 continuous months of weekly monitoring prior to May 12, 2005.	YES. Only if all WBC counts ≥ 3000/mm³ (and ANC ≥1500/mm³ if reported)
Every 2 weeks or weekly. Therapy interrupted after May 12, 2005, due to moderate leukopenia and/or granulocytopenia*, with consecutive monitoring since restart (rechallenge) of therapy.	NO. Only after 1 year of continuous weekly monitoring and then 6 months of continuous every two weeks monitoring from the date of restart (rechallenge) with all WBC/ANC above increased monitoring frequency values***.
Weekly therapy for ≤6 months	NO. Patient must have 6 continuous months of weekly monitoring, followed by 6 months of continuous monitoring every two weeks with all WBC/ANC above increased monitoring frequency values**.
Weekly therapy for ≥6 continuous months, but never monitored biweekly.	NO. Patient must have 6 continuous months of monitoring every two weeks with all WBC/ANC above increased monitoring frequency values**.
Increased Monitoring Frequency Requirements	
Patient is currently monitored monthly and experiences a WBC < 3500/mm³ and/or an ANC < 2000/mm³.	Monitoring should be done twice weekly until WBC/ANC values are ≥3500 and ≥ 2000, respectively. The patient can return to monthly blood work.
Patient is currently monitored every 2 weeks and experiences a WBC < 3500/mm³ and/or an ANC < 2000/mm³.	Monitoring should be done twice weekly until WBC/ANC values are ≥3500 and ≥2000, respectively. The patient should then be monitored every two weeks for 6 continuous months before progressing to monthly blood work.
Patient is currently monitored weekly and experiences a WBC < 3500/mm³ and/or an ANC < 2000/mm³.	Monitoring should be done twice weekly until WBC/ANC values are ≥3500 and ≥2000, respectively. The patient should then be monitored weekly for 6 continuous months before progressing to every two weeks, and then monthly, blood work.

**Prior to May 12, 2005 values for WBC and ANC counts requiring interruption of therapy were WBC ≤ 3000/mm³ and/or ANC ≤ 1500/mm³. After May 12, 2005 values for counts requiring increased monitoring frequency of therapy are WBC ≤ 3500/ mm³ and/or ANC ≤ 2000mm³, respectively.

Following discontinuation of therapy for any reason, the patient should have WBC and ANC count monitoring once a week for a minimum of 4 weeks. If at the end of 4 weeks WBC < 3500/mm³ and/or ANC < 2000/mm³, weekly monitoring should continue until WBC ≥3500/mm³ and ANC ≥ 2000/mm³.

Clozaril (clozapine) use is associated with a substantial risk of seizure, affected 1% to 2% of patients at low doses (below 300 mg/day), 3% to 4% at moderate doses (300 mg/day to 600 mg/day), and 5% at high doses (600 mg/day to 900 mg/day). Clozaril is contraindicated in patients with paralytic ileus. In clinical trials, Clozaril was associated with a 1% to 2% incidence of agranulocytosis, a potentially fatal blood disorder, which, if caught early, can be reversed. Mandatory monitoring of WBC counts and ANC's and drug dispensing as per the requirements specified in the package insert, provide an efficient means of determining developing agranulocytosis. Analysis of post-marketing safety databases suggests that Clozaril is associated with an increased risk of fatal myocarditis, especially during, but not limited to, the first month of therapy. Orthostatic hypotension may occur in some patients, especially during the initial phases of treatment, and can, in rare cases (approximate incidence of 1/3000), be accompanied by collapse and/or cardiac arrest. Analysis of clinical studies reveal that elderly patients with dementia-related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo. Patients with an established diagnosis of diabetes mellitus who are started on CLOZARIL should be monitored regularly for worsening glucose control (e.g., polydipsia, polyuria, polyphagia, and weakness).

Clozaril® (clozapine) 25mg and 100mg tablets

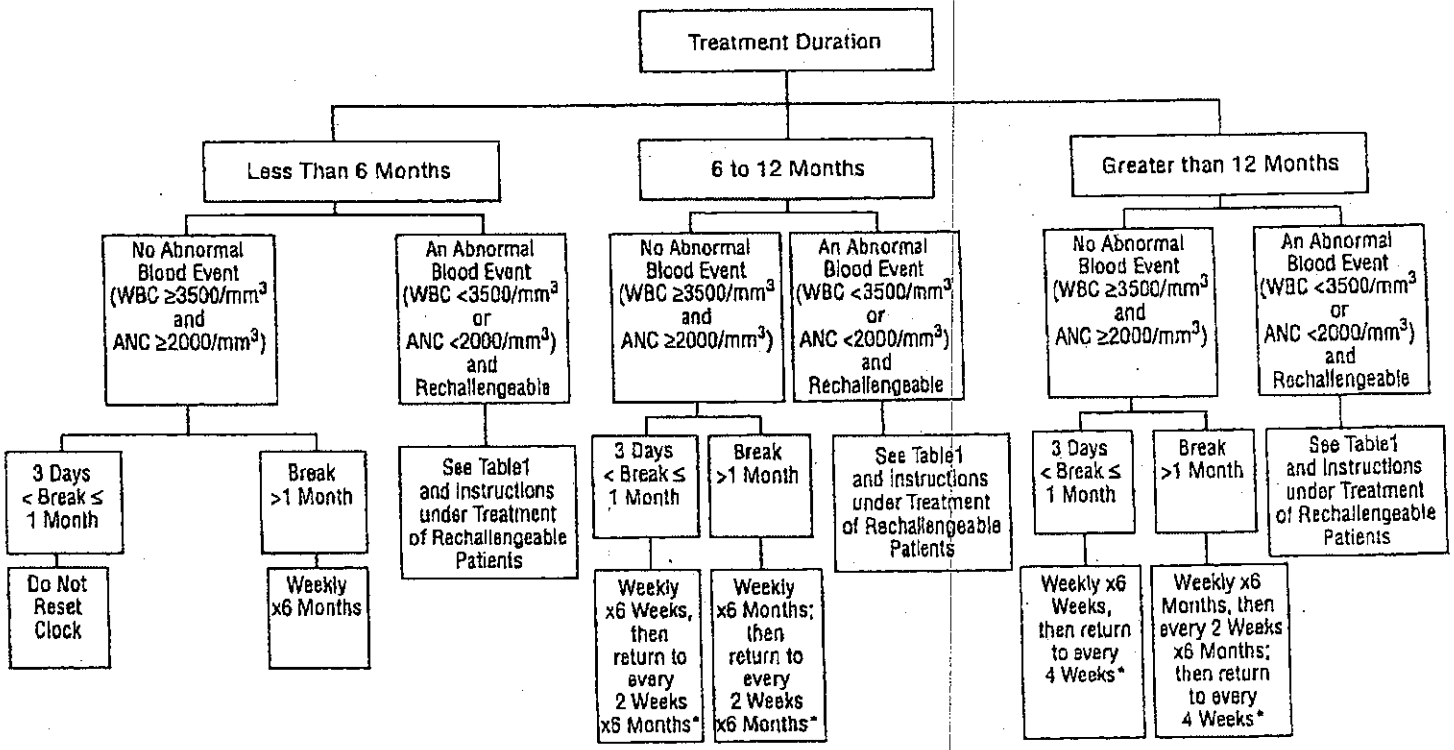
Table 1. Frequency of Monitoring based on Stage of Therapy or Results from WBC Count and ANC Monitoring Tests

Situation	Hematological Values for Monitoring	Frequency of WBC and ANC Monitoring
Initiation of therapy	WBC ≥ 3500/mm^3 ANC ≥ 2000/mm^3 Note: Do not initiate in patients with 1) history of myeloproliferative disorder or 2) Clozaril® (clozapine) induced agranulocytosis or granulocytopenia	Weekly for 6 months
6 months – 12 months of therapy	All results for WBC ≥ 3500/mm^3 and ANC ≥2000/mm^3	Every 2 weeks for 6 months
12 months of therapy	All results for WBC ≥ 3500/mm^3 and ANC ≥ 2000/mm^3	Every 4 weeks ad infinitum
Immature forms present	N/A	Repeat WBC and ANC
Discontinuation of Therapy	N/A	Weekly for at least 4 weeks from day of discontinuation or until WBC ≥ 3500/mm^3 and ANC > 2000/mm^3
Substantial drop in WBC or ANC	Single Drop or cumulative drop within 3 weeks of WBC ≥ 3000/mm^3 or ANC ≥ 1500/mm^3	1. Repeat WBC and ANC 2. If repeat values are 3000/mm^3 ≤ WBC ≤ 3500/mm^3 and ANC < 2000/mm^3, then monitor twice weekly
Mild Leukopenia --- Mild Granulocytopenia	3500/mm^3 > WBC ≥ 3000/mm^3 and/or 2000/mm^3 > ANC ≥ 1500/mm^3	Twice-weekly until WBC > 3500/mm^3 and ANC > 2000/mm^3 then return to previous monitoring frequency
Moderate Leukopenia --- Moderate Granulocytopenia	3000/mm^3 > WBC ≥ 2000/mm^3 and/or 1500/mm^3 > ANC ≥1000/mm^3	1. Interrupt therapy 2. Daily until WBC > 3000/mm^3 and ANC >1500/mm^3 3. Twice-weekly until WBC > 3500/mm^3 and ANC > 2000/mm^3 4. May rechallenge when WBC > 3500/mm^3 and ANC > 2000/mm^3 5. If rechallenged, monitor weekly for 1 year before returning to the usual monitoring schedule of every 2 weeks for 6 months and then every 4 weeks ad infinitum
Severe Leukopenia --- Severe Granulocytopenia	WBC < 2000/mm^3 and/or ANC < 1000/mm^3	1. Discontinue treatment and do not rechallenge patient 2. Monitor until normal and for at least four weeks from day of discontinuation as follows: • Daily until WBC > 3000/mm^3 and ANC > 1500/mm^3 • Twice weekly until WBC > 3500/mm^3 and ANC > 2000/mm^3 • Weekly after WBC > 3500/mm^3
Agranulocytosis	ANC ≤ 500/mm^3	1. Discontinue treatment and do not rechallenge patient 2. Monitor until normal and for at least four weeks from day of discontinuation as follows: • Daily until WBC > 3000/mm^3 and ANC > 1500/mm^3 • Twice weekly until WBC > 3500/mm^3 and ANC > 2000/mm^3 • Weekly after WBC > 3500/mm^3

*WBC=white blood cell count; ANC=absolute neutrophil count

ATTACHMENT

Figure 1. Resuming Monitoring Frequency after Interuption in Therapy.



*Transitions to reduce frequency of monitoring only permitted if all WBC ≥ 3500 and ANC ≥ 2000.

Subject: **Psychiatry**
Number: **P0011**
Effective Date: **12/21/05**
Last Revision: **4/10/07**
Title: **Use of Multiple Concurrent Antipsychotic Medications**
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Based on the consensus of ADC Psychiatric Staff, and the Pharmacy and Therapeutics Committee meeting on 7 June 2006, the following guidelines are presented for the use of multiple concurrent antipsychotic medications:

1. Use of multiple antipsychotic medications concurrently in an inmate shall only occur when no single formulary antipsychotic medication yields an adequate therapeutic response.

2. Initiating multiple antipsychotic medications concurrently in an inmate shall require approval as a non-formulary request consistent with the process described in Mental Health Procedural Instruction P0004.

3. Continuation of approved antipsychotic polypharmacy shall be consistent with Mental Health Procedural Instruction P003.